WHO/MSD/MDP/00.1
English Only
Distr.: General

Women's Mental Health:

An Evidence Based Review

World Health Organization
Geneva

WOMEN'S MENTAL HEALTH

AN EVIDENCE BASED REVIEW

Mental Health Determinants and Populations
Department of Mental Health and Substance Dependence
World Health Organization
Geneva
2000

Acknowledgements

Meena Cabral, Department of Mental Health and Substance Dependence, World Health Organization and Jill Astbury, Associate Professor and Deputy Director of the Key Centre for Women's Health in Society, University of Melbourne, Australia, wish to thank warmly the reviewers who provided insightful comments for the improvement of this document. They include: Dr Assia Brandrup-Lukanow, Regional Adviser, Women and Reproductive Health, WHO; Dr Herbert Friedman, Consultant, London, UK; Dr Claudia Garcia-Moreno, Evidence and Information for Policy, WHO; Dr Michelle Funk, Department of Mental Health and Substance Dependence, WHO; Ms Talat Jafri, UNIFEM, New York, USA; Ms Pirkko Lahti, The Finnish Association for Mental Health, Helsinki, Finland; Dr Lenore Manderson, University of Melbourne, Australia; Ms Naana Otoo-Oyortey, International Planned Parenthood Federation; Dr Judith A. Oulton, International Council of Nurses, Geneva, Switzerland; Dr T.K. Sundari Ravindran, Consultant in Women's Health, New Delhi, India; and Women's Health Bureau and Mental Health Promotion Unit, Health Canada, Ottawa, Canada.

Further copies of this document may be obtained from:

Mental Health Determinants and Populations
Department of Mental Health and Substance Dependence
World Health Organization
1211 Geneva 27
Switzerland

WOMEN'S MENTAL HEALTH: AN EVIDENCE BASED REVIEW

Table of Contents

Preface

We are pleased to present this evidence based review which contains a reappraisal of the status of women's mental health problems in different regions of the world. It updates and reactualizes a first publication on Psychosocial and Mental Health Aspects of Women's Health issued by the Divisions of Mental and Family Health in 1993.

Over the years, the work of many WHO departments has converged with the concerns of the Key Centre for Women's Health in Society, University of Melbourne, in documenting the impact of discrimination and low socio-economic status on the health of women. More recently, there has been a shift from a focus on "women" to a focus on "gender" as a critical determinant of health. We are committed to the integration of gender issues in all our work and to the utilization of gender analysis in the development of mental health policies and programmes. In line with the recommendations articulated in the Beijing Platform of Action, the Programme of Action of the International Conference on Population and Development, and the Convention on the Elimination of All Forms of Discrimination Against Women, we are strengthening attention to the tremendous health burden of women that is created by gender discrimination, poverty, social position, and various forms of violence against women.

In the Global Burden of Disease, it is estimated that depression will become the second most important cause of disease burden in the world by the year 2020. Women in developed and developing countries alike are almost twice as likely as men to experience depression. Another two of the leading causes of disease burden estimated for the year 2020, namely violence and self inflicted injuries, have special relevance for women's mental health.

This document adopts a health determinants framework for examining the evidence related to women's poor mental health. From this perspective, public policy including economic policy, socio-cultural and environmental factors, community and social support, stressors and life events, personal behaviour and skills, and availability and access to health services, are all seen to exercise a role in determining women's mental health status. Similarly, when considering the differences between women and men, a gender approach has been used. While this does not exclude biological or sex differences, it considers the critical roles that social and cultural factors and unequal power relations between men and women play in promoting or impeding mental health. Such inequalities create, maintain and exacerbate exposure to risk factors that endanger women's mental health, and are most graphically illustrated in the significantly different rates of depression between men and women, poverty and its impact, and the phenomenal prevalence of violence against women.

The document collects and analyses the latest research evidence pertaining to the study of these issues and identifies the most pertinent risk factors and social causes that account for much of the poor mental health of millions of women around the globe. It also highlights the current gaps in knowledge that must be addressed through cross-cultural epidemiological, behavioural and operational research, especially in the developing countries, since most of the present research is directed at the situation in the richer, developed countries. Finally, the document provides pointers to the most

pressing issues that need to be considered by national policy and programme authorities in order to improve the mental health status of women.

Although it is not intended to be used as a guideline *per se*, it is our hope that readers will benefit from the analysis of evidence provided in this document and be guided on the priorities for research and action in this critical area. As a follow up to this review, we will address the need for a more practical, user-friendly guide to assist health workers and managers in becoming aware of their vital role in alleviating the mental health problems of women through a variety of individual and community-based interventions. In the meantime, WHO along with its collaborating centres, will continue to provide technical support to countries upon their request, to develop culturally sensitive policies and programmes addressing the individual and social risk factors that account for the pervasive damage to so many women's mental wellbeing in all countries of the world.

Jill Astbury
Associate Professor and Deputy Director
Key Centre for Women's Health in Society
WHO Collaborating Centre
University of Melbourne
Australia

Meena Cabral
Scientist
Department of Mental Health
and Substance Dependence
World Health Organization
Geneva

Introduction

In the discussion of the determinants of poor mental health of women, it has become imperative to move from a focus on individual and "lifestyle" risk factors to a recognition of the broader, economic, legal and environmental factors that affect women's lives and constrain their opportunities to control the determinants of their health. Social factors can and do change within and between countries in ways that promote or retard gender development and empowerment (UNDP 1997). The identification and modification of the social factors that influence women's mental health holds out the possibility of primary prevention of certain mental disorders by reducing their incidence.

In this review, a gendered, social model of health is used to investigate critical determinants of women's mental health with the overall objective of contributing to improved, more effective promotion of women's mental health that is grounded in research evidence. Risk factors for mental disorder as well as for good mental health are addressed and where possible, a clear distinction has been made between the opportunities that exist for individual action and individual behaviour change and those that are dependent on factors outside the control of the individual woman.

Where poverty, inequality and social disadvantage are entrenched, the health beliefs of individuals may count for nothing in terms of being able to reduce behavioural risk factors. As Farmer (1996) has observed 'Throughout the world, those least likely to comply are those least able to comply.'

It is essential to recognise how the socio-cultural, economic, legal, infrastructural and environmental factors that affect women's mental health are configured in each country or community setting. Only by responding to the complexities and particularities of women's lives can health promotion strategies hope to increase the opportunities women want and need to control the determinants of their health.

If programmes to promote women's mental health focus on the reduction of individual 'lifestyle' risk factors, they may neglect the very factors that bring that lifestyle into being. Moreover, if such programmes fail to meet their objectives, they carry a considerable risk of misattributing that failure to the women towards whom they were directed. Such a misattribution precludes an examination of the features of the programmes themselves or of the social circumstances that the programmes did not or could not address.

A focus on behavioural risk factors that makes the individual responsible for her health may have deleterious effects. The acceptance of personal responsibility is not necessarily empowering. Indeed, 'it may encourage self blame and despondency' and make behavioural change less likely' (Ziebland et al., 1998). Neither self blaming nor victim blaming are compatible with promoting good mental health. Both, by concentrating on 'failings' within the individual may militate against the likelihood of thorough programme evaluation (Pill, Peters & Robling, 1993). In addition, victim blaming may increase the very health risks and health behaviours, that health promotion programs are designed to reduce. A study of cocaine using pregnant women gives a disturbing insight into the possible consequences of such an approach:

Most of them were aware of the potential harm to the fetus and ironically used more cocaine to avoid remorse and self loathing (Chavkin & Kandall, 1990) Evaluation of intended and unintended, positive and negative outcomes is thus integral to comprehensive health promotion.

Although an attempt has been made to draw research evidence from both developed and developing countries, it has to be acknowledged that like many other health and educational activities, most funding and most research comes from richer, developed countries rather than poorer, developing ones.

To help clarify the meaning women themselves ascribe to mental health and various forms of psychological distress, findings from qualitative research have been employed to augment those from quantitative research. Descriptions of life situations, case studies and direct quotes from women themselves have been used to vivify the contexts in which emotional distress, depression, anxiety and other psychological disorders occur. It is hoped that such first hand accounts of the experiences of poverty, inequality and violence will assist in developing a more accurate understanding of the structural barriers women face in attempting to exercise control over the determinants of their mental health and in effecting behavioural change. Both are needed to better inform the promotion of women's mental health. Moreover, subjective perceptions of health are significantly related to psychological well being and utilisation of the health care system (Ustin & Sartorius, 1995).

Women's views and the meanings they attach to their experiences have to be heeded by researchers, health care providers and policy makers. Without them, research and the evidence it gathers, service delivery and policy formation, will be hampered in responding to women identified health priorities, problems and needs. Moreover, all three will be ignorant of the nature and magnitude of unmet needs and unaware of the factors influencing women's utilisation of health care.

Organization of the document

To proceed from a gendered, social model of health, women's mental health in this document is appraised according to theoretical models that can adequately explain how 'proneness' and 'vulnerability' arise out of women's social position and their differential susceptibility and exposure to risk factors that might correlate with or lead to poor mental health outcomes. Consequently, the document is divided into four parts as follows:

> The first part contains a brief discussion of gender differences in social position, impact of change in economic policies, and human development from a global perspective. This is useful in providing a broad context from which to consider the specific risk factors that are discussed in subsequent sections.
>
> In part two, a brief review of evidence based social theories of women's depression are provided with an emphasis on the research with women in a variety of countries carried out over more than twenty years by George Brown, Tirril Harris and their colleagues (Brown & Harris, 1978; Brown &

Prudo, 1981; Brown Andrews & Harris, 1986; Brown &Harris, 1989, Brown, Bifulco & Andrews, 1990; Brown & Moran, 1994; Brown, Harris & Hepworth, 1995; Brown, Harris & Eales, 1996; Brown & Moran, 1997; Brown, 1998). The aim of this review is to identify and elucidate how characteristic features of women's social roles and social position affect their attainment and maintenance of positive emotional well being or increase their likelihood of experiencing poor mental health. The features identified are then related to the specific mental health risks factors evaluated in subsequent sections in order to gauge their relevance.

Parts three and four consider the impact of poverty and violence, as gender specific risk factors, on women's mental health. In relation to the 1981 WHO definition of mental health, both poverty and violence can be seen to significantly interfere with the promotion of subjective well being, the optimal development and use of mental abilities and to be incompatible with justice and conditions of fundamental equality.

PART ONE

GENDER, DEVELOPMENT AND HEALTH

Background

The World Health Organization's Ottawa Charter for Health Promotion (1986) sees health as multidimensional and espouses a social model of health. It defines health as 'a positive concept emphasising social and personal resources, as well as physical capacities.'

The emphasis of the social model of health on a positive concept of health contrasts with the traditional biomedical view. This has been more concerned with biological factors in the production of illness and disease and with ways of improving diagnosis and treatment once illness and disease have occurred.

Within the social model of health, while human biology and health care remain important determinants of health, they are part of an expanded health field concept (Raeburn & Rootman, 1989). The idea of the health field stresses the importance of both individual behavioural factors and material, economic and psychosocial factors, and their complex reciprocal relationships, in determining health and illness.

Health cannot be fragmented or reduced to a single causal factor and women's mental health is no exception. Good mental health is intrinsically important, conferring a subjective sense of emotional well being on the individual woman and extrinsically important, representing a significant resource to the broader society in which she lives and works.

A necessary first step towards a socially contextualised health promotion model of women's mental health is to have a definition of mental health which can be usefully applied to women.

This paper will take as its starting point the definition of mental health used in the 1981 WHO report on the social dimensions of mental health, which states that:

> ***'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 has several advantages in relation to women's mental health because it:

- stresses the complex web of interrelationships that determine mental health and that the factors that determine health operate on multiple levels
- goes beyond the biological and the individual

- acknowledges the crucial role of the social context
- highlights the importance of justice and equality in determining mental well being

The definition does not mention gender, but gender can and does impact on the production of mental health at every level - the individual, the group and the environment- and is critically implicated in the differential delivery of justice and equality. Gender configures both the material and symbolic position women occupy in the social hierarchy as well as the experiences which condition their lives. Consequently, in this report gender is conceptualized as a powerful structural determinant of mental health that interacts with other structural determinants including age, family structure, education, occupation, income and social support and with a variety of behavioural determinants of mental health. Understood as a social construct, gender must be included as a determinant of health because of its explanatory power in relation to differences in health outcomes between men and women.

> ***These asymmetries are manifested not only in terms of differential susceptibility and exposure to risks - for example vulnerability to sexual violence, but also, fundamentally, in the power of men and women to manage their own lives, to cope with such risks, protect their lives and influence the direction of the health development process. This balance of power has generally favoured men and relegated women to a subordinate, disadvantaged position (Pan American Health Organization, 1995).***

A gendered, social determinants model offers the only viable framework for examining evidence on all relevant factors related to women's mental health. From this perspective, public policy including economic policy, socio-cultural and environmental factors, community and social support, stressors and life events, personal behaviour and skills, and availability and access to health services, may all be seen to exercise a role in determining women's mental health status.

The importance of gender differences in mental health is most graphically illustrated in the significantly different rates of major depression experienced by women compared with men. A recent comprehensive review, Gender Differences in the Epidemiology of Affective Disorders and Schizophrenia (Piccinelli & Homen, 1997), found that women predominated over men in lifetime prevalence rates of major depression in all the general population studies conducted so far. The twelve studies of this kind noted in the review were carried out in a range of countries including the USA, Puerto Rico, Canada, France, Iceland, Taiwan, Korea, Germany and Hong Kong.

When rates of major depression at each site were standardised to the Epidemiologic Catchment Area five site household sample (Kessler et al, 1994) for the age group 18-64, the female to male sex ratio ranged between 1.6 and 2.6. The need for the effective promotion of good mental health for women and the reduction of psychological distress and disorder has never been more urgent.

In The Global Burden of Disease (GBD), Murray and Lopez (1996) estimate that by the year 2020, unipolar depression will be the second most important cause of

disability burden in the world. This is an increase on 1990, when it ranked fourth of the fifteen leading causes.

According to Murray and Lopez (1996) the burden of mental illness has been seriously underestimated by traditional approaches that focus on mortality rates as the primary measure of adverse health outcomes. Projections used in GBD show that psychiatric and neurological conditions could increase their share of the total global burden of disease from 10.5% in 1990 to 15% in 2020.

The need to focus on ill health and morbidity has also been emphasised in the area of women's health. Health related data that is solely biomedically based cannot adequately inform an understanding of the morbidity experienced by women. As mortality rates decline, it becomes increasingly critical to address physical and psychological morbidity, increase satisfaction with health care services and improve quality of life, if improvements in women's health are to be achieved.

Yet, the health care system remains preoccupied with mortality. Saltman (1991) argues that:

> ***One of the ways in which the existing health care system discriminates against women is in its focus on mortality: women's major health needs lie in improving morbidity rather than mortality (p.35)***

The tools currently in use to measure health status exacerbate this difficulty by themselves having a gender bias. The Australian Health Targets and Implementation Committee (1988) considers that most such tools do not adequately address women's health issues and may actually be misleading in their measuring of certain health conditions because:

> ***They may show women to have better health in some areas, but they are no good at identifying where women are not as healthy as men, such as mental health (p.32).***

Reducing morbidity is an essential prerequisite to the improvement of women's mental health.

As women in many countries are approximately twice as likely as men to experience depression and it is the most prevalent psychiatric disorder any significant reduction in the overrepresentation of women who are depressed would make an important contribution to lessening the global burden of disease. Women's mental health is a significant public health issue.

Another two of the fifteen leading causes of disease burden estimated for 2020-violence (12) and self-inflicted injuries (14) have particular relevance to women's mental health (Stark & Flitcraft, 1995; Stark & Flitcraft, 1996). These conditions not only diminish the quality of women's lives but can lead to their deaths.

In 1990, for women in their peak reproductive years, aged 15-44, suicide was second only to tuberculosis as a cause of death. That year, more than 180,000 women in China killed themselves and another 87,000 women in India died in fires. (Murray

and Lopez, 1996). Suicide has been conceptualised as an escape from the self, or a lethal behavioural response to blocked escape (Baumeister, 1990).

If the 10 major risk factors for the global burden of disease for 1990 are examined, their social position determines that women will be disproportionately exposed to several of these risk factors. The ten risk factors, in order of importance, are malnutrition, poor water supply, sanitation and personal/domestic hygiene, unsafe sex, tobacco use, alcohol use, occupation, hypertension, physical inactivity, illicit drug use and air pollution.

The promotion of women's mental health, like health promotion in general, relies on establishing a process composed of a variety of possible elements that singly or together enable women as individuals or members of their communities to increase control over the determinants of their mental health and thereby be in a position to improve their health status and health outcomes.

Social position, poverty and health

A strong inverse relationship exists between social position and physical and mental health outcomes. Adverse health outcomes are two to two and a half times higher amongst people in the most disadvantaged social position compared with those in the highest (Dohrenwend, 1990; Najman, 1993; Bartley & Owen, 1996).

Such health differentials have been found in a number of countries including Finland, Norway and Sweden (Rahkonen et al, 1993; Lahelma et al, 1994) the United Kingdom (Macran et al, 1994; Arber, 1997), the United States (Belle, 1990) and Australia (Najman, 1993). The link between mental health and low income amongst urban women has also been documented in Bombay, Olinda and Santiago (Blue, Ducci, Jaswal et al, 1995)

Socioeconomic circumstances, social support and health related behaviours all have independent effects on health, but cluster together and are mutually reinforcing. Compared with people in high socioeconomic groups, those in low socioeconomic groups are far more likely to have lower levels of resources, education, poorer living and working environments and lower levels of social support.

Health inequalities also derive from other sources including differences related to age, marital status, genetic factors, ethnic background and access to health care and health related information. As well as differences in access, the quality of the health care women receive when they do encounter the health care system affects satisfaction with care and exerts an influence on psychological health. Being allowed to retain a sense of control and having an active role in decision making has been found to be associated with choosing a medical rather than a surgical termination of pregnancy (Mamers, Lavelle, Evans et al, 1997) and in reduced risk of depression following caesarean delivery (Brown, Lumley, Small et al, 1994).

Indigenous people worldwide are particularly likely to experience disadvantaged socioeconomic circumstances, discrimination and poor health outcomes (Feinstein, 1993; Whitehead et al., 1993; Power, 1994; Kunst, Geurt & Van den Berg, 1995;

Bartley & Owen, 1996; Macran, Clarke & Joshi, 1996; Wadsworth, 1997; Wilkinson, 1997).

Specific evidence regarding the relationship between women's social position and their mental health will be discussed in more detail in Part 2.

Variations in health status occur because of the way in which factors acting singly or more often in concert with one another produce disadvantage. Even though the reduction of a single risk factor such as smoking confers clear health benefits, the substantial elevation of a single risk factor may not be as dangerous as small elevations of multiple health, behavioural and social risk factors. In reality, reciprocal relationships often exist between health, socio-economic and occupational status, residential location, exposure to health and safety risks, the presence of lifestyle and behavioural risk factors such as unsafe sex, violence, smoking, alcohol consumption, lack of exercise and poor diet, past and present life stressors, community and social support and the availability of health services.

It is vital, therefore, that women's health in general and women's mental health in particular, are examined within a social model which gives an account of the physical and mental health effects of common life stressors and events that are disproportionately experienced by women. Clearly this cannot be confined to childbearing and reproductive events but must also include the impact of poverty, single parenthood, the 'double' shift of paid (often low paid) and unpaid work, employment status, lower wages, discrimination, physical, emotional and sexual violence and the psychological costs of childcare and other forms of caring work.

Where women lack autonomy, decision making power and access to independent income, many other aspects of their lives and health will necessarily be outside their control (Okojie, 1994) including their susceptibility to communicable diseases (Hartigan, 1999).

The different levels of susceptibility and exposure to various kinds of health risks that women face compared with men will inevitably set limits on their opportunities for exercising control over the determinants of their mental health. Elucidating the defining characteristics of women's lives is a necessary precondition for any convincing, socially contextualised account of the gender specific risk factors for adverse mental health outcomes. In the next part of the report, a broad overview of women's current social position will be provided.

Influences on women's well being: Gender development

The World Health Report (WHO, 1998) states categorically that:

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

A brief summary of gender differences in social position and human development from a global perspective is useful in providing a broad context from which to consider the specific risk factors that will be discussed in subsequent sections.

Two measures that attempt to operationalize gender development and capture the disparity between women and men have been developed by the United Nations Development Program (UNDP). One is the gender related development index (GDI) and the other is the gender empowerment measure (GEM) The GDI aims to rank countries on their absolute level of human development and their relative scores on an index of gender equality. The same three indicators that are used in the human development index (HDI), namely life expectancy, educational attainment and income are used for the GDI. The GEM provides a measure of gender inequality in the key areas of economic and political participation and decision making.

How relevant and valid the indicators used in measuring human and gender development has been widely discussed. After all, notions of the human typically encompass social, cognitive, aesthetic, ethical and spiritual qualities and are not confined or reduced to the three indicators of life expectancy, educational attainment and income used in the UNDP measure.

Both measures have received criticism. Dijkstra and Hanmer (1997) who have developed an alternative measure of socioeconomic gender inequality, argue that this separate measure of gender inequality is needed in order to be able to examine absolute levels of gender inequality. The UNDP measure examines levels of gender development and inequality from a relativistic viewpoint and sees gender development as a function of human development. In consequence, specific conditions or treatment which affects women only cannot be ascertained.

The UNDP measures may be less than perfect, but they remain useful tools for providing an overview of differences in gender development and empowerment between countries. All the available data point to the universally inferior position of women. As the 1997 UNDP report (1997) puts it: ‘no society treats its women as well as its men’.

In the 146 countries for which the GDI was calculated (UNDP 1997), none had a GDI value higher than its HDI value. Some 41 countries had a GDI value of more than 0.800 but almost as many other countries (39) had a GDI value of less than 0.500, indicating that women in these countries did not reach even half the level of human development, as defined according to the three indicators of life expectancy, educational attainment and income. In other words, women were unable to access the development afforded to their male counterparts.

Paradoxically, even in a measure dedicated to directing attention to gender inequalities, human development becomes equated with the development of men while gender seems to be a quality monopolised by women.

Table 1 shows selected findings for the 10 highest and for 10 middle ranking GDI countries, how these compare with HDI rankings and the difference between the two. The 10 lowest ranking GDI countries are not shown, as the GDI rank and HDI rank for each of them was identical.

A positive difference shows that a country performs relatively better on gender equality than on average achievements alone, while a negative difference indicates the opposite.

Table one
10 Highest GDI ranking countries

GDI rank	*HDI rank*	*HDI rank minus GDI rank*
1 Canada	1	0
2 Norway	3	1
3 Sweden	10	7
4 Iceland	5	1
5 USA	4	-1
6 France	2	-4
7 Finland	8	1
8 New Zealand	9	1
9 Australia	14	5
10 Denmark	18	8

10 middle ranking GDI countries

GDI rank	*HDI rank*	*HDI rank minus GDI rank*
48 Malta	33	-15
49 Bulgaria	59	10
50 Mexico	46	-4
51 Kuwait	48	-3
52 Estonia	60	8
53 Fiji	43	-10
54 Mauritius	53	-1
55 Lithuania	64	9
56 Bahrain	40	-16
57 Croatia	65	8

It is readily apparent that human development is not synonymous with gender development in either developed or developing countries. However, the rankings also underline that moves towards gender equality can be effected at various stages of development and in diverse cultural and political settings.

Gender empowerment

If gender empowerment rankings are examined, Nordic countries fare extremely well, occupying four of the top five rankings. Moreover some developing countries outperform richer, industrialised ones in achieving gender empowerment in political,

economic and professional activities. For example, the GEM rank for Barbados is 14 while that of the United Kingdom is 20. Some developed countries such as Greece, with an HDI ranking of 19, have a much lower GEM ranking of 56.

There are strong but not invariant links between gender inequality and human poverty and there is a pronounced disparity in income poverty and literacy levels between people living in rural versus urban areas. Progress in reducing poverty and increasing human development is thus uneven both within and between countries. Disparities between ethnic groups are prominent and especially poor progress is found in relation to indigenous people in countries as diverse as Vietnam, Canada, Australia, Bolivia and Mexico.

Socioeconomic differentials exist in all countries and above a certain level of income, life expectancy and various other health outcomes appear to be most closely tied to inequalities in income or low relative income (Macintyre, 1997; Wilkinson, 1998). Large socioeconomic inequalities in the United States of America and relatively small ones in Sweden go hand in hand with the health inequalities found in the two countries (Kunst, Geurts & Van den Berg, 1995; Kaplan et al., 1996). This relationship indicates that a steep socioeconomic gradient, with a large discrepancy between the best compared with the worst off, is antagonistic to increasing overall health status.

Gender development clearly benefits from more even income distribution, as reflected in the relative shift that can be seen to occur in Table one between the HDI and GDI rankings in Sweden and the USA respectively. When gender development is compared with the human poverty index (HPI) both the four lowest ranking countries in HPI also have the four lowest GDI rankings (Sierra Leone, Niger, Burkina Faso and Mali) and three of the four developing countries with the highest HPI rankings also have the highest GDI rankings (Costa Rica, Singapore and Trinidad and Tobago). Nevertheless, gender empowerment can be achieved even in very poor countries. For example some countries which have a high incidence of income poverty (defined by the $1 a day poverty line) such as Guatemala with 53% income poverty and Guyana with 46% income poverty have GEM rankings in the top third of all countries rankings, 29 and 33 respectively. The converse is also true. Countries with a very low incidence of income poverty, such as Morocco with only 1% income poverty is ranked 72 in the GEM rankings. No country has a GEM equal to or greater than 0.800. The UNDP report (1997) concludes that ‘The low values (of GEM) make it clear that many countries have much further to travel in extending broad economic and political opportunities to women.’

Economic policies, access and equity

For women in general and especially for those who are members of ethnic minorities and indigenous groups, a critical issue is how income, opportunities and resources are distributed within countries.

Economic growth alone does not guarantee improvements in health, poverty or social justice. The UNDP report (1997) states that economic growth accounts for, at most, 50% of the reduction in income poverty. When human poverty is added (non income

dimensions of poverty such as the percentage of a population not expected to survive to age 40, who do not have access to safe water, are illiterate and have unsustainable levels of forest and woodland), the degree of correlation between economic growth and the two forms of poverty- income poverty and human poverty- may be further attenuated. This is apparent in the range of relationships to be found between income poverty and human poverty.

Some countries have reduced income poverty when Gross Domestic Product has increased but have still presided over increases in human poverty; other countries have decreased both income and human poverty and yet others have lower levels of human than income poverty. Clearly, economic growth is not a sufficient condition for improvements to human or gender development.

Economic growth reduces poverty most when it is associated with increases in the employment, productivity and wages of poor people and least when, as the 1997 UNDP report puts it: 'big chunks of GDP go out of the country...such as to pay international debt or purchase weapons.' Moreover, the falls in HDI in 30 countries between 1993-1994, reflecting decreases in life expectancy and real Gross Domestic Product per capita, illustrate how precarious efforts to improve human development can be.

The continuing impact of HIV/AIDS was a significant factor in the declining health and human development in many Sub Saharan African countries. Armed conflict and economic stagnation and decline were also powerful antagonists to the goals of human development as shown by the decreasing HDI rankings of a number of Eastern European and CIS countries.

Recent evidence also suggests that policies which produce significant decreases in social cohesion and increases in inequality, will engender poor health outcomes. An analysis of the factors associated with decreasing life expectancy between 1990-1994 amongst both men and women in Russia, reported that premature deaths were concentrated in the 30-60 year age group. The most important predictors of decreased life expectancy were the pace of economic transition, characterised by a high turnover of the labour force, inequality and decreased social cohesion together with a concomitant increase in crime and alcoholism (Walberg et al., 1998).

The significance of social capital as a public good that is protective of health but is also vulnerable to erosion and underproduction when left to economic market forces has now been evaluated. In the US, Kawachi, Kennedy, Lochner et al (1997) investigated social capital as indicated by the extent of interpersonal trust between citizens, norms of reciprocity and density of civic associations (membership in a wide variety of voluntary organizations, using data collected from 39 states. They found that income inequality was strongly correlated with low per capita group membership and lack of social trust. Both were associated with total mortality and specific mortality caused by coronary heart disease, malignant neoplasms and infant mortality. Income inequality appears to be especially influential in poor health. Kennedy et al (1998) examined the effect of inequalities income within each state while controlling for individual characteristics including household income. Data from 50 US states was analysed. Those living in states with the greatest inequalities in income were 30% more likely to report their health as fair or poor than those living in states with the

smallest inequalities in income, independent of the effect of household income. Subsequent research (Kawachi, Kennedy & Glass, 1999) confirmed that low social capital was also associated with having poor or fair self rated health. Those living in areas with the lowest levels of social trust more often reported poor self rated health, even after the effects of low income, low education and smoking were statistically controlled. These findings on the relationship of social capital to health illustrate how disinvestment in social capital can be the conduit through which income inequality exerts its effects on mortality at the population level. The findings underline the need for policy makers and researchers to consider community level as well as individual level determinants of health , to include social capital as a key factor in notions of sustainable development and to measure how economic restructuring effects social capital.

Economic policies and women's social position

Wilkinson (1997) has observed that what makes a difference to health is 'more a matter of people's relative income and status in society than of their absolute material living standards.' Women have lower income relative to men and are overrepresented amongst those living in absolute poverty, accounting for around 70% of the world's poor (UNDP, 1995, 1997). Inequality and poverty are highly gendered. Any increase in inequality through cuts in the social wage or social welfare or other forms of disinvestment in social capital necessarily fall most heavily on women.

The erosion of social capital can proceed as a direct result of changes in economic policy within a country or from conditions attached to financial aid to a country by external donors or such institutions as the IMF or World Bank. Structural adjustment loans to developing countries are characterised by conditions that demand the adoption of free market economic policies to foster a climate that is attractive to foreign investment. Along with trade liberalization, export promotion and the devaluation of local currencies, the privatization of the state sector is likely to be pursued. This is typically accompanied by cutbacks to public sector employment and social welfare spending. Health care, education and even basic foodstuffs can rapidly become unaffordable, especially to the poor (Bandarage, 1997). Sharp reductions in general social spending in response to IMF loan conditions and increased inequality between the bottom 20% of the population and the top 20% has been well documented (Kolko,1999). Economic policy decisions can therefore initiate sudden, disruptive and severe changes to the income, employment and living conditions of large numbers of people, who are powerless to resist them. As will be seen in the next section of this report, disruptive, negative life events that cannot be controlled or evaded, are powerfully related to the onset of depressive symptoms. The other side of trade liberalization and much vaunted increases in the 'flexibility' of the labour force can be widespread anxiety, insecurity and the loss of any sense of predictability in life.

In today's world, a poor person is 'more likely to be African, to be a child, a woman or an elderly person in an urban area, to be landless, to live in an environmentally fragile area and to be a refugee or a displaced person (UNDP, 1997) Some of these categories overlap. Most women are landless, for example, and with longer life expectancy in most countries, are overrepresented amongst the elderly. Not

surprisingly women with responsibility for children are the largest group of people living in poverty. The interlinkages between gender, mental health, social position and barely sustainable income levels despite heavy work have been illustrated in a study in the Volta region of Ghana, West Africa. Avotri & Walters, (1999) found that the combination of financial insecurity and financial and emotional responsibility for children, together with heavy workloads, a sense of work being compulsory and a gender division of labour exacted a heavy toll on women's emotional health. Psychosocial problems associated with their work roles were described by three quarters of the women in this study and mentioned much more often than reproductive health problems.

Even in developed countries such as the United States, Canada and the United Kingdom and Australia the numbers entering poverty as supporting mothers continue to increase (Belle, 1990; UNDP, 1997; Shaver 1998). Economic reforms can adversely affect women in a number of ways when governments pursue policies of economic deregulation. If public ownership of basic services like water is transferred into private hands costs can rise; if public housing is sold off and women cannot afford to pay for housing in the private market, homelessness can increase; if social security is cut and welfare entitlements to maternity benefits, childcare and pre-school education are reduced then access is effectively denied and when there is a move to 'casualise' the workforce, women are most affected because 'casualisation' tends to occur most in the areas of employment with the highest rates of female participation, such as the service sector. One of the adverse effects of gloablization for women has been an increase in poor quality, insecure jobs and weakened social support systems (Loewenson, 1999)

For women in paid work, significantly more receive low wages than their male counterparts. Moreover, 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 . Between 1993-1995, more than 30% of women were in low paid jobs in Japan, USA and the UK. An exception to this pattern was Sweden where less than 10% of female workers were in low paid work (UNDP, 1997). The link between greater gender parity in paid work and high gender development and gender empowerment ratings is reflected in Sweden's very high rankings on these measures.

Obviously both men and women are affected by economic adjustment. But what needs to be recognised by policy makers is that this can occur in distinctly different ways for men and women because of the separate roles they play and the different constraints they face in responding to policy changes and shifts in relative prices.

The gender specific impacts of changes in economic policy need to be accounted for in any evaluation of their efficacy and the gender neutral assumptions on which such policies proceed must be questioned.

In an analysis of the impact of Structural Adjustment Programs (SAP) on women, Kirmani and Munyakho (1996) argue that there is a gender specific social cost of adjustment that is not easily measured and consequently not counted in macroeconomic indicators. For example, these indicators ignore the gendered division of labour and incorrectly assume that changes in income, food prices and public

expenditure affect all members of the household in the same way. Gross national product (GNP) and formal employment are highlighted, and the informal work of child care, gathering fuel and water, preparing food, housecleaning and nursing the sick and the elderly are excluded from the definition of economy and work.

With the strains imposed by economic adjustment, the burden associated with the multiple roles, tasks and responsibilities women are expected to assume will increase and have negative implications for their health. Any time women spend on their own health necessarily entails very high opportunity costs when discretionary time is minimal.

For poor, unskilled women the impact of international trade changes may have been to expand employment opportunities, but predominantly in low paid jobs. As LeQuesne (1996) points out:

> ***'While women have only their cheap unskilled labour to offer, there is clearly a danger that their working conditions will deteriorate, the insecurity of their jobs will increase, and their standard of living will remain low.' (p195)***

The 1997 UNDP report argues that time should be counted as a resource. Increases in time pressure on women as a result of changed economic policies must therefore be counted as a cost of such policies.

Nzomo (1994) cited in Kirmani and Munyakho (1996) goes further and asserts that the goals of Structural Adjustment Programs (SAPS) are only achievable at the cost of longer and more arduous working days for women who have to increase their labour within the market and the household.

> ***'It would appear that SAP's, as designed by the (World) Bank as well as other bilateral and multilateral agencies, seem to count on women's special capabilities for coping with crisis, namely, endurance, perseverance, and ingenuity. It is women's coping mechanisms that both the male-dominated governments and the Bank have exploited in implementing structural adjustment policies that clearly hurt women more than men.'***

It is ironical that within the economic policies of structural adjustment women's time and unpaid labour can be simultaneously treated as a flexible, dependable even essential means of achieving SAP goals, but never be counted in the estimation of a country's Gross Domestic Product (GDP). If unpaid domestic work were counted, it has been estimated that GDP would rise by as much as 25% (UN, 1991).

One study of the effects of structural adjustment policies in Guayaquil, Ecuador, revealed that a decline in real wages caused an increase in women's employment and that the accompanying increased time burden resulted in reduced health care utilization (Moser, 1991).

Women have not been consulted about their involvement in various activities or their opinion of health policies whose success depends on that very involvement. By virtue of their higher pre-existing levels of poverty, women are likely to be

disproportionately affected by the policies of structural adjustment. Associated health sector reform reinforces this effect. Health sector reform tends to be characterised by reduced government spending on the health care system, 'innovations' such as shorter hospital stays and 'hospital in the home' and the implicit or explicit demand that more will be achieved with less so as to increase efficiency and better 'target' health treatments and interventions. Efficiency can entail job shedding and increase rates of unemployment or less secure employment for nurses and other health care professionals.

Health sector reform can severely impact on women in their assumed gender role as unpaid carers of the sick. Women are expected to cope with an increased burden of more complex care when looking after sick family members who previously would have been able to remain in hospital. As unpaid, 'conscripted' health care workers, it appears that women are meant to simply absorb the personal, financial, emotional and opportunity costs of increased care.

Assuming that women not only can but will want to increase their time and commitment to ensure the goals are met of health policy makers on maternal and child health programs, for example, is another example of this systematic 'oversight' in health policy formulation. Such gender stereotyping relies on the continuation of gender role socialization which 'gives women primary responsibility for the care of people (women's role in social reproduction) without relieving them of the shared responsibility for providing the means for that care (women's role in economic production)' (Antrobus, 1993).

In particular, policies that enshrine the 'user pays' principle are likely to differentially disadvantage women. The unstated 'flip side' of 'user pays' is quite simply, if you can't pay, then you don't use. Of course, by focussing only on the positive image of someone actively using a facility, like a health care centre, or a resource, like water, the human rights and social justice issue of the relationship of equity and access to need, is neatly sidestepped. However, it is obvious that those who have least to pay with, are forced to use least, regardless of their needs. The introduction of, or increase of fees, for previously low or no cost health services have resulted in declining attendances at government health facilities and lower rates of immunisation against childhood diseases in Swaziland (Yoder, 1989). Corresponding increases in rates of disease can rapidly reverse any previously achieved gains in health or development.

In Kenya, where the Ministry of health began charging fees for patients attending public outpatient facilities at the end of 1989, the cost of paying for the diagnosis and treatment of sexually transmitted diseases (STD's), constituted a very real impediment to the majority of the poor seeking health care. Moreover, decreases in attendance rates were higher amongst women than amongst men. While the mean monthly attendance for men decreased by 40 per cent, that for women decreased by 65 percent compared with the preuser charge period (Munyakho, 1994, cited in Kirmani & Munyakho, 1996). Clearly, if there is an increase in untreated STD's and the spread of HIV/AIDS because of inability to afford treatment, any short term economic gain will be quickly obliterated.

Economic policies which reduce available funding for services can result in the closure or undermining of the effectiveness of services and initiatives previously set

up to improve women's position. Many of those interviewed about the effectiveness of *delegacias* (women's police stations) in Brazil, in improving the investigation rate of domestic violence, attributed low investigation rates primarily to diminishing economic and political support (Thomas, 1994).

If governments, as a result of SAP's cut their health expenditures and other core social expenditures in education and welfare, the impact will inevitably be felt most by those in greatest need- the poor, women and children. It is not possible to off-load indefinitely the burden of health, care and other costs of adjustment onto women without this having serious adverse effects on their physical and mental health and thus ultimately compromising the very economic goals being pursued.

Evidence relating specifically to the effect of restructuring on women's mental health is beginning to emerge. Patel et al (1999) undertook an analysis of mental health, as indicated by the common mental disorders of depression, anxiety and somatic symptoms, in four restructuring countries. Data was obtained from primary care attenders in Goa, India, Harare, Zimbabwe and Santiago, Chile and community samples from Pelotas and Olinda, both in Brazil. Strong, common associations were found across these data sets between female gender, low education and poverty and the common mental disorders. This study reveals how gender inequality is linked to economic inequality and rising income disparity. All three function as potent risk factors for those mental disorders in which women are known to predominate.

The financial crisis that began in Asia and saw precipitous falls in currency values and living standards, rises in unemployment and the reversal of hard won gains in development, has spread to other countries. In Russia, where decreasing life expectancy has occurred, one quarter of the labour force had not been paid for six months or longer by early 1999 (Kitney, 1999).

The brunt of these changes has fallen on working people, the poor and particularly on women, who constitute the vast majority of the world's poor. Serious questioning has begun of what previously amounted to articles of economic rationalist faith, such as the unfettered liberalization of global financial markets, the unlimited mobility of capital and unregulated economic growth. At the 1999 World Economic Forum, this questioning was evident in the forum's motto of 'Responsible Globality', reflecting an emerging consensus around the need for adequate national and international frameworks of financial regulation.

Unless these frameworks are devised, the social capital and personal resources so vital to health will remain vulnerable to global financial forces outside the control of individuals or indeed governments. Economic restructuring can not only deplete social capital and compromises the physical health of those experiencing the greatest inequality (Kawachi & Kennedy,1997; Kennedy et al, 1998; Kawachi et al, 1999) but this inequality appears to exert a gender specific effect on women's mental health (Patel et al, 1999). In such circumstances, the health promotion objective of enabling women to increase control over the determinants of their mental health, can be nothing more than an unrealisable and cruel illusion.

Social position, rights and mental health promotion

It is imperative to look more closely at how differences in the way women are treated, so evident in the gender development and gender empowerment rankings, affect their mental health. Evidence on how social factors and women's social position affect their mental and emotional well being is crucial to the development of a workable model of women's mental health promotion. Moreover, the extremely wide inter country variations in the level of gender development suggest that these social factors are amenable to change and modification.

The great advantage of identifying modifiable, social determinants of women's mental health is their alteration and reduction offers the possibility of reducing the incidence of mental health problems. In other words, their identification and reduction can contribute to the primary prevention of such problems. By contrast, even if a great improvement occurred in the detection and treatment of psychological problems once they had developed and were identified in women presenting in general health care settings (and there is certainly scope for that, Ustin & Sartorius, 1995) such a response would only improve secondary prevention. The incidence of such problems and their social determinants would remain unchanged and could continue to rise.

The conspicuous disparity between human development and gender development rankings discussed earlier, attests to the stubborn persistence of gender based inequality and injustice with regard to the basics of education, income and life expectancy. Although justice and equality are essential elements in the attainment of mental health (WHO, 1981) the presence of injustice and inequality, such long standing features of women's lives, has been systematically ignored in research on women's mental health. Perhaps ubiquity confers invisibility. Gender blindness to the possible influence of systemic injustice and discrimination as inducements to depression and despair is readily apparent in the large body of research on how women's reproductive functioning affects their mental health. In a review of research on the link between reproductive function and psychiatric syndromes (Gitlin & Pasnau, 1989), not a single study mentioned, let alone examined how the denial of women's reproductive rights might affect their mental well being.

It seems astonishing that issues such as forced sterilisation, having one concerns dismissed or trivialised, not being asked for consent to invasive procedures or tests, being denied privacy or dignity when intimate gynaecological examinations are performed, having low or no access to accurate health information or to safe, effective and affordable methods of fertility regulation, safe care in pregnancy and childbirth and affordable methods of preventing or effectively treating sexually transmitted diseases, have never been seen to play a role in women's emotional well being. Inadequate reproductive health care and the violation of reproductive rights result in physical harm even death. Despite this, their psychological dimensions have been ignored, almost as if women's bodies and what is done to them had no effect on their minds and could be denied.

Just as biological or endocrinological factors alone do not adequately explain women's mental health status or gender disparities in affective disorders (Piccinelli & Homen, 1997), neither do they explain the disproportionate burden of reproductive

health problems women face worldwide. These problems are intimately connected to the social, educational (including health educational) economic and political disadvantages women experience and have significant psychological consequences of their own. They have received inadequate attention by policy makers (Okojie, 1994).

Little education, early age at marriage, adolescent pregnancy, repeated pregnancies at short intervals due to lack of access to or the cultural unacceptability of family planning, son preference and less food being given to girls and women, all increase the likelihood of reproductive health problems. All are influenced if not caused by social and cultural, not biological forces.

The emphasis on women's reproductive biology is likely to stem from the view that women's health is synonymous with and reducible to those illnesses or conditions related to women's reproductive health. This view is indicative of a dualistic style of thinking characterised by the use of binary terms where one term is always privileged in relation to the other. The privileged term is regarded as the norm and its opposite is defined only in relation to it and is devalued accordingly, for example, rational/irrational,objective/subjective,thinking/feeling,culture/nature,mind/body,masculine/feminine.

The splitting of body from mind and the identification of women and their health with the body in general and reproductive functioning in particular has led to a neglect of women's mental health and its social structural determinants. Using biological difference from men as the chief organising principle, women's health, in the past, was seen to fit within the ambit of obstetrics and gynaecology. Within this biomedical framework, women's health was confined to such biologically based issues as breast and cervical cancer, pre-menstrual syndrome, contraception, pregnancy and childbearing, psychoendocrine problems, postnatal disorders and disorders of menopause.

Reducing women's health to women's reproductive health has had numerous negative consequences for the state of scientific knowledge (Eichler & Parron, 1987; Lee, 1988; Arber, 1991; Mastroianni, Faden & Federman , 1994; Vlassoff, 1994; Astbury, 1996). These include:

- An inadequate understanding of and research on gender differences in health and illness.

- A paucity of information pertaining to basic physiology and pharmacokinetics in women.

- Pervasive gender bias in research such as less attention being paid to conditions to which women are more vulnerable and the assumption that health through the lifespan follows the same course for women as it does for men.

- The view that illnesses and diseases should be treated in the same way for men and women in the absence of any research that supports this assumption.

- Insufficient attention to the use of interventions, drugs administered to women and adjustment of drug dosages for women according to their average weight rather than that of the 70 kilogram average white male.

- Delay in seeking evidence or developing appropriate research tools to measure the relationship between differentials in women's social class and position and their health outcomes.

- The neglect of social factors, discrimination and gender specific negative life events and stressors in favour of reproductive and endocrinological explanations of women's higher rates of depressive and other psychological disorders.

- An emphasis on the health, including the mental health, of women as mothers and a relative neglect of other aspects of women's health and other periods of the lifecycle.

It was not until 1990 that the National Institute of Health (NIH) in the United States issued guidelines mandating the inclusion of women in clinical trials, and not until June 1993 that the NIH Revitalisation Act was passed by the US Congress. This Act introduced new requirements for the inclusion of women and minorities in federally funded clinical studies except where specific criteria for the exclusion of these groups could be satisfied (Mastroianni, Faden & Federman, 1994).

Gender comparisons regarding health outcomes have been bedevilled by the use of two different conceptual frameworks. In one, men are seen primarily in terms of their occupational role with occupation conceptualised as a structural variable. In the other, women are primarily researched in terms of their family roles. The focus on the primacy of women's family roles has led to their paid work being regarded as an additional role rather than as a structural variable in its own right thus further complicating and confounding comparisons made on the basis of gender (Arber, 1991). The emphasis on women's reproductive health and women's roles as wives and mothers has been particularly evident in the health policies and health research conducted in developing countries. However, as Avotri and Walters (1999) study of Ghanaian women showed, the main health concerns women identified were related to psychosocial health problems associated with heavy workloads. Not only has the mental health of women in developing countries from a psychosocial multi-level perspective received little attention (Patel et al, 1999) including the mental health effects of reproductive functioning and reproductive health care, but women's occupational health has also been a casualty of the long standing preoccupation with women's reproductive functioning (Loewenson, 1999).

The proportion of a woman's life spent in childbearing will vary greatly between countries according to their stage of demographic transition. In industrialised, developed countries in the late stage of the demographic transition where fertility rates are at or lower than replacement value and life expectancy for women is approximately 80 years, then a woman who has, for example, two full term pregnancies will spend one and a half years, or less than 2% of her lifetime in childbearing. By contrast, in developing countries with high fertility rates and low life expectancy in the early stage of the demographic transition, a woman who has six full term pregnancies and a life expectancy of 52 years will spend nearly four and a half

years being pregnant or around 9% of her lifetime in childbearing – a five fold difference. The real disparity is likely to be even greater than this because the example does not include miscarriage, the increased likelihood of pregnancies not going to full term or extended periods of breastfeeding. In addition, while age of having a first child has risen in developed countries to the late 20's, women in developing countries face greater obstetrics risks associated with pregnancies occurring in adolescence and after the age of 35, due to grand multiparity.

The higher risks of adverse reproductive outcomes for women in the latter compared to the former category is most starkly represented in terms of lifetime risk of maternal death. A woman in Pakistan has a 1/38 lifetime risk of maternal death while a woman in Australia has a 1/4900 risk (WHO 1997). Such relativities need to be kept in mind in determining the relevance of equating women's health with women's reproductive health in different countries.

A narrow focus which makes women's health equivalent to women's reproductive health is likely to result in initiatives which concentrate their attention on married women of childbearing age and ignore children and adolescents as well as adult and older women who are unmarried or childless. In developed countries, this is equivalent to ignoring women's health throughout most of their lives. In less developed countries, this emphasis has deflected attention from important gender differences regarding the social, economic and personal impact of malaria and schistosomiasis and those diseases which have particularly adverse psychosocial consequences for women because they carry social stigma and alter physical appearance, such as tuberculosis, lymphatic filariasis and leprosy. Women's occupational health issues have also received little attention (Vlassoff, 1994; Hartigan, 1999).

Women's mental health concerns

Women's concerns with psychological well being extend across the life cycle and cannot be confined to reproductive functioning. In attempting to differentiate women's mental health concerns from those of men, it might be argued that they could be defined as including, but not being limited to, conditions, diseases or disorders which are unique to women; occur more commonly in women; have different risk factors for women; or follow a different course in women relative to men. However, this approach omits those mental health conditions shared by men and women but for which women may receive different forms of treatment even when the same symptoms are manifested (Mastroianni, Faden & Federman, 1994). For example, an Australian study found that even when there were similar numbers of men and women with high scores on the General Health Questionnaire (a screening measure of psychiatric disorder) that primary care physicians classified signficantly more women as disturbed than men (Redman et al, 1991). Unless such differences in treatment have a sound evidential basis, they are suggestive of gender stereotyping, lead to inappropriate care such as the prescription of psychotropic drugs for women who are not disturbed and are a significant source of concern.

Women's mental health concerns also extend beyond specific conditions or problems. They encompass the structures that govern the provision of health related education,

information and health care delivery, the processes that influence women's interactions with the health care system and the factors that determine whether the treatment they receive is gender sensitive. One important influence is caregivers' professional training and education. Without an understanding of a gendered, social model of health, quality of care can be compromised (Mammen & Astbury, 1997).

At the present time, an accurate needs assessment of women's mental health, an essential element in effective health promotion, remains hampered by inadequate sources of data, an overly biological, individual focus in research and theoretical models which often neglect to consider how women's low social status and material circumstances intersect with their family roles and their participation in paid employment in determining mental health outcomes. The omission of these social factors from studies of women's 'vulnerability' to mental health problems, amounts to a form of selection bias which precludes the very possibility of examining how gender inequalities might determine women's emotional well being.

PART TWO

DEPRESSION IN WOMEN

Social theories of depression

As Murray & Lopez (1996) make clear, depression, as well as being the most prevalent psychiatric condition, is making an increasingly heavy contribution to the global disability burden. Depression is not only the most frequently encountered women's mental health problem, but ranks as the most important women's health problem overall.

While unipolar depression is expected to be the second most significant cause of global disease burden in 2020 (up from 4th in 1990), conditions arising during the perinatal period, more traditionally recognised as encompassing women's health concerns, are expected to decrease in importance from 3rd in 1990 to 11th in 2020.

Earlier attempts to explain the approximately 2:1 ratio of depression in women compared with men took this difference in prevalence to be indicative of a biologically based sex difference in women's proneness or vulnerability to depression compared with men. Explanations invoking genetic, neurotransmitter and endocrinological differences related to reproductive hormones have all been advanced. The search for biological causes of women's higher rates of depression continues unabated (Crow, 1986; Rubinow, 1992; Halbreich & Lumley, 1993; Nolen-Hoeksma & Girgus, 1994; Blehar & Oren, 1995).

> ***The present review will investigate women's higher rates of depression and certain other disorders within a gendered, social model of health.***

It has long been known that the social environment is of critical importance for health. Variations in both mortality and morbidity rates by social class are a consistent finding of epidemiology (Macintyre, 1986; Dohrenwend, 1990; Dohrenwend, Levav, Shrout et al, 1992; Najman, 1993; Kessler et al., 1994; Bartley & Owen,1996; Stansfield, Head & Marmot, 1998).

The evidence suggests that environmental stressors such as life events and chronic difficulties contribute significantly to the lower social class predominance for non psychotic disorders like depression and anxiety. These non psychotic or neurotic neurotic mental disorder are also referred to as Common Mental Disorders (CMD) in reference to their high prevalence in the community. CMD are the third most frequent causes of morbidity in adults and represent a significant public health problem (Ormel et al, 1994) Less access to supportive social networks, at both an immediate personal, contextual level and at broader societal level, has also been linked with higher levels of morbidity and mortality (Brown & Harris, 1978; Berkman & Syme, 1979; Brown & Prudo 1981; Milo, 1981; Paykel, 1994; Kessler et al., 1994; Turner & Marino,

1994). More recently, the research of Kawachi and Kennedy and their colleagues (1997, 1998, 1999) has revealed the importance of inequality and low social capital in determining health and Patel et al's (1999) analysis of data from four societies undergoing restructuring identified a particular effect of rising income inequality on women's risk of common mental disorders.

Identifying the particular hazards or risk factors to which women's social position exposes them and ascertaining their effect on emotional well being is important for its own sake, to develop better approaches to treatment based on an enlarged understanding of the causes of mental illness in women and to provide the accurate information researchers and policy makers need for the development of effective mental health promotion strategies.

As Stein (1997) sees it, women's health outcomes are inextricably bound up with their lower social position:

> ***Perceptions of equity and equality directly affect health…there is a direct effect on health where one stands in the scale of things in society…it is no longer physical causes but social and cognitively mediated processes.***

This review will concentrate on examining evidence on whether and to what extent women's perceptions of their place in the scale of things and the events which trigger these perceptions, together with the cognitively mediated processes that accompany them, affect their mental health status. An attempt will be made to evaluate how the risk factors to which women are disproportionately exposed, contribute to the burden of disease associated with depression.

Depression has been chosen as the primary outcome variable to be explained, not only because it is the most prevalent women's mental health problem but also because it is likely to be accompanied by other psychological disorders which are more common in women such as anxiety disorders. Indeed, Kessler et al. (1994) reporting on the US National Co-morbidity Survey noted that women had higher prevalences than men of both lifetime and 12 month comorbidity of three of more disorders. For example, amongst the affective disorders for both lifetime and 12 month prevalence the most common disorder for women was a major depressive episode, with a 21.3% lifetime and a 12.9% 12 month prevalence. Amongst the anxiety disorders the lifetime prevalence for both social phobia and simple phobia was just over 15%, while the 12 month prevalence was 9.1% and 13.2% respectively.

As Brown, Harris and Eales (1996) have pointed out the frequency of these depression and anxiety has implications for comorbidty:

> ***'On the basis of multiplying independent probabilities, the number of comorbid conditions will increase as the base rates of disorder increase in a population.' (p53)***

Very wide variations in the prevalence of CMD's are reported between different countries. In the World Health Organization (WHO) Psychological Problems in General Health Care study, the form, frequency, management and outcome of common psychological disorders in primary care patients was investigated using a

standardized method of recruitment and assessment across centers. Participating centres included Ankara, Turkey; Athens, Greece; Bangalore, India; Berlin, Germany; Groningen, the Netherlands; Ibadan, Nigeria; Mainz, Germany; Manchester England; Nagaski, Japan; Paris, Framce; Rio de Janeiro, Brazil; Santiago, Chile; Seattle, Wash; Shanghai, China and Verona, Italy. Ustin and Sartorius (1995) reported a more than twelve fold difference in current prevalence rates for depression for women, if the place with the lowest rate of depression, Nagaski (2.8%) is compared with the highest, Santiago (36.8%). In most centers women had higher rates of current depressive episode than men.

Similar, wide variations between countries in rates of depression have been reported by Brown (1998). In commenting on general population studies of women in Zimbabwe, London, Bilbao, the Outer Hebrides, rural Spain and rural Basque Country between 18 and 65 years, the percentage of women meeting criteria for depression varied from a high of 30% in Zimbabwe to a low of 2.4% in the Basque Country. That environmental factors and especially, negative, irregular, disruptive life events can trigger depression is suggested by the strong correlation between such events and depression in all six countries.

Psychiatric comorbidity, with depression as a common factor, is a characteristic finding of many studies on women's mental health (Brown & Anderson, 1991; Mullen et al., 1993; Ustin & Sartorius, 1995; Kessler et al., 1994; Brown, Harris & Eales, 1996). In the WHO multinational study, for all specific psychiatric disorders, comorbidity rates exceeded 50% (Ustun et al, 1995).

On the other hand, some researchers have criticised the notion of co-morbidity in relation to non psychotic disorders, arguing that it is an artefact produced by imposing a categorical rather than dimensional model on the symptoms of mental disorder.

Goldberg (1996) believes this leads to conceptual dogmatism:

> ***Another problem with categorical models is that those who use them come to believe in them. Instead of realising that a categorical diagnosis is both provisional and hypothetical, the true believer reifies it. (p45)***

Nevertheless, when analysing three different sets of data using the 40 item Present State Examination with a dimensional approach, the depression and anxiety axes remained 'reasonably invariant', while differences between data sets emerged with the phobic dimension (Goldberg 1996; Ormel et al., 1995). The issue of whether depression is a distinct clinical entity is relevant to the exercise of successful classification which assumes that different categories of mental disorder are mutually exclusive. If they are not mutually exclusive, but co-exist to a high degree, a dimensional approach is indicated.

Most of the studies reviewed in this report, however,adopt a categorical approach to the diagnosis of symptoms. For example, in the very large, WHO multi country study of psychological problems in general health care, already mentioned, 62% of participants were women. In this study it was found that women's overall rates of depression across participating centres were 1.89 times higher that those of men and

psychiatric co-morbidity was found to be most prevalent amongst depressed patients (Ustin & Sartorius, 1995).

Gender differences in rates of depression are maintained across the life span with prevalences among elderly women generally higher than those among men (Vazquez-Barquero et al., 1992; Beekman, Kriegsman & Deeg, 1995; Zunzunegui et al., 1998). In exploring possible reasons for an increasing prevalence of depression with increasing age, Mirowsky and Ross (1992) note that sex is the only known factor that could account for this increase through differential survival which favours women who in turn have higher rates of depression.

On the other hand, a recent Canadian National Population Health Survey found results at variance with the common finding that depression increases significantly with age. Wade and Cairney (1997) reported that the prevalence of depression in the Canadian survey decreased until age 65 and there was only a slight increase afterwards for both men and women. In keeping with the two large American studies (Mirowsky & Ross, 1992; Kessler et al.,1992) the lowest age point for depression was around 45 years (Wade & Cairney, 1997). It is interesting to consider the differences between Canada and the US in the light of the higher ranking for gender development and empowerment rankings noted in Part One of this report that favour Canadian women. Another recent study conducted in Australia, whose GDI ranking is higher than its HDI ranking, also reported a statistically significant decline with age in the symptoms of depression for women. Risk factors that similarly declined with age included the neuroticism score, the frequency of adverse life events, being seriously short of money and having had parents who separated or divorced (Henderson et al, 1998).

In the Ustin and Sartorius (1995) study, almost half of the patients with at least one psychiatric disorder had a disorder from at least one other cluster of psychiatric disorders. These clusters included most disorders, apart from alcohol dependence, in which women have been found to predominate (Eaton & Kessler, 1985; Russo, 1990). The clusters were depressive episode, agoraphobia, panic disorder and generalised anxiety; somatisation, hypochondriasis and somatoform pain and alcohol dependence. In the current report, these comorbidities will be discussed where they arise as findings from research conducted on specific topics such as the psychological sequelae of childhood sexual abuse, but will not be a focus of attention in their own right.

Social theories of depression in women

The first in depth study of the role of social factors in the development of depression in working class British women was carried out by Brown and Harris, more than twenty years ago. Their book ‘Social Origins of Depression: A Study of Psychiatric Disorder in Women’, published in 1978, represented a significant departure at the time from the theorising about depression in women that dwelt on intrinsic biological, hormonal and reproductive factors in its model of mental health. Since that time, research on women has been undertaken in a number of other countries, as previously noted. All the research of Brown, Harris and their co-workers has underscored the importance of social factors and significant severely stressful life events and chronic life difficulties in triggering depression in women and for this reason will be

discussed in some detail. The details of these events and their frequency vary from country to country, but the use of standardised measures and research methods permits useful comparisons to be made between countries.

Psychosocial factors have been found to contribute significantly to both depression and anxiety, with the population attributable risk around 60% to 65% estimated from a number of population based samples (Brown, Andrews & Harris, 1986; Finlay-Jones, 1989; Brown, 1998). However, there is some evidence that current social circumstances other than severely threatening life events involving danger, are less important than childhood adversity for the development of anxiety. Conversely, childhood adversity, current marked interpersonal difficulties, lack of social support and severe events, all appear to be related to depression. There is also an increased risk of a depressive episode occurring in the presence of ongoing anxiety (Goldberg et al., 1990; Brown & Moran, 1994; Brown, Harris & Eales, 1996).

In another large study, Kessler et al. (1994) found that anxiety disorders were more likely than substance use disorders or affective disorders to have occurred in the 12 months before participants in their research were interviewed,. They conclude from this that anxiety disorders are more chronic than either of the other two disorders. In contrast with the research of Brown, Harris and colleagues who stress the importance of childhood rather than current circumstances for anxiety, Kessler et al's data (1994) suggested that current socioeconomic status is more powerfully related to anxiety than affective disorders and believe that lack of resources is more likely to exacerbate worries and fears than lead to sadness. However the conflicting findings arise out of studies using different research designs and methodologies and are not strictly comparable. Kessler and his colleagues carried out a cross sectional prevalence study, while Brown and his colleagues have typically adopted a prospective longitudinal approach better suited for elucidating temporal sequence in causal relationships.

As the research of Brown, Harris and their co-workers has continued, it has posed new questions and generated additional evidence around the nature of the severe events and the types of provoking and vulnerability factors that might promote depression. In consequence, their theoretical model of depression has become increasingly detailed.

Nevertheless, their social model of depression continues to comprise three interconnecting main elements. These are provoking elements or severe life events such as important losses and disappointments or major difficulties lasting for two or more years, vulnerability factors, such as a non confiding marriage which increase risk in the presence of a provoking agent and symptom formation factors which influence the form, but not the risk of a depressive disorder occurring, such as the co-morbidity of an anxiety disorder.

In their initial study, Brown and Harris (1978) identified four vulnerability factors that increased the chances of a woman developing depression in the presence of a stressful life event. These factors were parental loss before the age of 17, particularly the loss of one's mother before the age of 11, the presence at home of three or more children younger than 14, a poor, non confiding marriage and the lack of full or part time employment.

Thus childhood adversity as well as current difficulties has always played a role in their explanation of depression in the lives of adult women. Childhood adversity is theorised to be associated with adult depression through its link to vulnerability factors like low self esteem.

In recent research, Brown, Harris and Hepworth (1995) reported that 85% of women from the community (as opposed to a patient group) who developed 'caseness' for depression in the 2 year study period experienced a severe event in the 6 months before onset. For depression to occur, they have documented that the severe event or events will be accompanied by provoking agents and vulnerability factors, especially those associated with low self-esteem and inadequate support. A matching of the nature of a current severe event with a pronounced ongoing difficulty has also been found to be critical (Brown, Andrews & Harris, 1986; Brown, Bifulco & Andrews, 1990; Brown, 1998).

While Brown and Harris and their colleagues have emphasised the importance of poverty in increased rates of depression and have researched working class British women from the outset, gender as a structural determinant of poor mental health and the status quo governing social arrangements has never been investigated. However, new risk factors, closely linked to gendered experience, have emerged. In particular, systematic inquiries have been made about abuse and violence in both childhood and adulthood and measures of adversity which include these topics have been developed over the last ten years (Brown, Bifulco & Andrews, 1990; Bifulco, Brown & Adler 1991). For example, the index of adult lifetime adversity is based on adverse experiences in adult life up to the year before women participate in their first research interview. Such experiences include the death of a child of any age, death of a husband or partner, two or more abortions, sexual abuse, and physical violence in the marriage or relationship. Thus, the depressogenic potential of gender specific experiences like abortion and intimate violence are now being examined in the research.

Brown, Harris and Eales (1996) argue that:

> ***'The losses and abuses would be expected to have acted adversely not only on the availability of support, but also to have increased the negative elements of her self-evaluation.'***

Findings on the relationship between violence and depression, will be discussed in more detail in Section two.

Characteristic features of severe events: humiliation and entrapment

The characteristic features of the provoking, severe events which lead to depression and have recently received greater attention in research, will be now examined.

In order to make greater use of the full descriptive material collected from their Life Events and Difficulty Schedule (LEDS), Brown, Harris and Hepworth (1995) developed a new measure to reflect this material. The new measure, like the previous one is researcher rather than participant rated. It concentrates on eliciting the

likelihood of feelings of humiliation and entrapment following a severely threatening event and is used in conjunction with the existing measures of loss and danger. The severity of events is assessed in terms of immediate and more long term impact of the situation up to 14 days after the event has occurred. Events are also classified with regard to the dimensions of loss and danger. Loss can include the actual loss of a person, through for example death or separation, the loss of a role or of resources, such as might follow unemployment and the loss of a cherished idea. Danger is defined as the threat of a future loss. In reality, the same event can involve both loss and danger.

Using a hierarchical rating system, the researchers tested the hypothesis, with both a patient and non patient sample, that loss or danger would play a much less important aetiological role in the development of depression, once the humiliation and entrapment aspects of severe events were taken into account. As predicted, humiliation and entrapment emerged as highly significant predictors of the onset of depression when severe events occurred. Almost two thirds of such events in the six months before the onset of depression involved being trapped and humiliated. In relation to the hierarchical scheme employed to examine onset of depression, almost three quarters of the severe events involved entrapment or humiliation, while around 22% involved loss alone and only 5% concerned danger alone. Even so, the researchers believe that this estimate of the importance of entrapment and humiliation in severe events and depression may be too low.

> ***'These estimates of the role of this particular experience may turn out to be conservative, given that self reports of feelings actually experienced were not taken into account.'***

Significantly, the provoking severe events in almost all instances, concerned a core relationship or tie. Coyne (1994) has also theorized that depression is linked to devaluation and rejection.

'Self in relation' theorists have also argued that women generally subscribe to an ethic of care and consequently place a high degree of importance on the quality of their personal relationships. Certainly, women have been found to meet more of the 'costs of caring' than men by spending more time helping and providing care to others in their social networks (Umberson et al, 1996; George et al, 1998). It has been stressed that the level of psychological investment in such relationships is pivotal in determining women's sense of self and self regard or esteem (Jordan, Kaylan & Surrey, 1991). Women with low self esteem who seek reassurance from partners but receive rejection and devaluation are particularly likely to experience emotional distress and depression (Katz, Beach, Joiner et al, 1998).

Jack (1991) in an interview based study of depressed women in the US advances a similar view. She stresses that the importance women place on their personal relationships with husbands and partners tends to cause them to make efforts to avoid conflict and suppress anger in order to preserve these relationships. Jack believes such efforts occur largely because 'inequality stifles a woman's direct communication'. The result, according to Jack, is a form of self censorship that she describes as 'silencing the self'. It is this self silencing, in the service of attempting to maintain interpersonal harmony, that is responsible for much depression. So from this

perspective, the most important loss involved in women's depression, is actually a loss of a robust and authentic sense of self.

The suppression of anger appears to be related to the perception of a lack of mutuality in relationships. Adopting a self in relation perspective, Sperberg and Stabb (1998) in a study of more than 200 US college educated women aged between 18 and 54 years, found that lower levels of mutuality and higher levels of suppressed or inappropriately expressed anger were associated with depression, with the lack of mutuality being particularly important.

Brown, Harris and Hepworth's (1995) finding that the likelihood of depression during the follow-up period was increased when women experienced a loss or sense of defeat in relation to a core role or relationship for which they had been rated as showing marked commitment at their first interview, offers additional weight to the previous findings.

The aetiological importance of experiences of loss and defeat in relation to core ties, also recalls very strongly the work of earlier attachment theorists. For instance, Bowlby (1980) in his work on infant attachment postulated that depression is a common response to loss of attachment objects.

Depression also occurred in a small percentage of cases where major life difficulty was present, even without a provoking event, but less than 2% of episodes in the community sample and less than 10% in the patient series occurred in these circumstances (Brown, Harris & Hepworth, 1995).

Humiliation remained a defining characteristic of the life difficulties encountered. The majority of women in the patient series spoke of being persistently humiliated or 'put down' by a husband or father. For example one woman said of her husband:

> ***'He puts me down continually, shouting and swearing, walking out of the room if I try and discuss anything.'(p17)***

Another said of her father:

> ***'My father is always very cruel. He invents new mental tortures and throws and smashes things.'(p17)***

Brown, Harris and Hepworth (1995) added that this father had sexually molested his daughter in the past. Another example concerns a woman who had been told by her husband during an argument that later led to a marital separation, that she was abnormal, because of her epilepsy and was not fit to be a mother.

These examples underscore the importance of the interpersonal quality of the marital relationship and of partner support, as distinct from the mere fact of being married or partnered, in modulating emotional well being.

Obviously, humiliation is not conducive to forging a confiding, supportive relationship. In a previous study (Brown, Andrews & Harris, 1986), an important qualification to the protective role of partner support was discovered. In looking more

closely at the role played by support, the researchers found that the timing of support was critical. Support from a core tie had to be forthcoming at the time of a crisis if it was to be protective. If a woman believed she would be able to rely on support from her partner or another person, only to find that she was 'let down' when a crisis occurred, then the likelihood of depression was increased.

The continual refinement of concepts and measures to ensure their accuracy and sensitivity to the complexity of psychological responses and an openness to the possible importance of events not previously considered is a feature of the work of Brown, Harris and their colleagues. Recently, Brown (1998) has provided a useful review of the most important concepts to have emerged from their research to date. An example of this is found in their questioning of whether the definition of loss used in the LEDS might be too broad, and whether it could result in events being incorrectly categorised (Brown, Harris & Hepworth,1995). They give the example of a woman who manages to leave a violent, abusive husband after many years, who would be rated as having experienced a loss. In this case, they hypothesise that 'any depressogenic effect is likely to come from recognising the hopelessness of finding the kind of relationship she desires, rather than from the loss of something that in a real sense had been largely lost before.' In other words, it is the meaning attached to an event, or its symbolism, not the event per se, which must be captured accurately if valid constructs of depression are to be developed:

> ***'Probably equally significant to being humiliated and devalued is what is symbolised by such atypical events in terms of the woman's life as a whole- in particular, the experience of being confirmed as marginal and unwanted.'(p19)***

On the other hand, autonomy and control, as the obverse of entrapment and humiliation, appear to play a highly significant role in lessening the risk of depression occurring in the context of what might otherwise be considered as a loss.

Brown, Harris and Hepworth (1995) reported that depression following separation from a core tie was mediated by the presence or absence of control. When a separation was initiated by the woman, only about 10% of such subjects subsequently developed depression. Alternatively when the separation was almost entirely initiated by the other person, around half the women developed depression. The rate of depression increased again if the discovery of infidelity was not followed by separation.

Social mentalities and rank

The idea that depression is closely connected to a sense of loss and defeat, especially that characterised by entrapment, and humiliation denoting devaluation and marginalisation, has also been advanced from a slightly different perspective by another group of researchers (Gilbert, 1992; Craig, 1996; Allan & Gilbert, 1997; Gilbert & Allan, 1998).

Most recently, Gilbert and Allan (1998) have developed scales with sound psychometric properties to investigate the role of defeat and entrapment in depression

from the perspective of social rank theory. A sense of entrapment typically occurs when a strong motive to take flight is blocked and has also been called ‘arrested flight’ (Dixon et al., 1989).

Feelings of inferiority, low self esteem, shame and being of low rank have commonly been found amongst depressed people (Gilbert 1992; Allan & Gilbert, 1995). Submissive, dependent and non assertive behaviour is stereotypically feminine behaviour which is still considered desirable in many countries, has also been documented in relation to depression (Allan & Gilbert, 1997). Female gender is synonymous with having a lower rank as the entrenched disparities between human development and gender development discussed in the first section of this report make clear. As noted there, the 1997 UNDP report observed that ‘no society treats its women as well as its men’. Presumably this fact has not escaped women themselves nor failed to influence their self perceptions.

Social rank theory highlights several key variables in the development of depression. These include perceptions of the self as inferior or in an unwanted subordinate position, low self confidence and behaving in submissive or non assertive ways, having a sense of defeat in relation to important battles, and at the same time, wanting to escape but being trapped.

The role of rank in relation to well being and depression has also been explored in the context of paid work. Karasek’s (1979) model has been utilised to examine the relationship of work characteristics such as skill discretion, job demands, decision making authority and work social support to depression amongst different grades of British civil servants.

Stansfield, Head and Marmot (1998) found that the rank or grade of employment was significantly related to well being. Not surprisingly, work characteristics, especially skill discretion and decision authority were closely related to employment grade and made the largest contribution to explaining differences in well being and depression. Those in the highest grades had the highest levels of well being and the least depression and those in the lowest grades had the highest levels of depression. Those in the lowest employment grades also had a higher prevalence of negative life events and chronic stressors and less social support. Interesting gender differences to emerge were that women’s well being was improved more by contact with friends than relatives and that material problems were more important for women than men in explaining the gradient in well being.

Women traditionally receive less pay and have lower status jobs than men. Even when men and women report similar workload demands, Karasek found that women often had to cope with such demands while exercising less control over the pace of the demands than men and for this reason he concluded that women’s jobs can be more stressful.

Gilbert and Allan (1998) have examined whether the social rank factors of defeat and entrapment interact with and are more significant than subordinate self perception and submissive behaviour. Like Brown, Harris and their co-workers, they compared a patient group and a non-patient group, in this case, university students. As both groups included men and women gender comparisons could be made. Similarly, they

stressed the quality of emotional responses and the nature of specific relationships in determining the likelihood of depression. For example they found that perceptions of being trapped and wishing to escape were separable, and theorised that the strength of the motivation to escape may be particularly important for the onset of depression.

Further, they argued that the reasons people feel trapped may be differentially predictive for depression. Thus being trapped or obligated to remain in specific relationships may have different psychological implications from being trapped by a lack of resources. Again, internal entrapment as evidenced by feelings of wanting to escape from oneself may initiate emotional connotations and consequences which differ from those provoked by external entrapment, or feeling entrapped by a situation or other people.

To distinguish the effect of defeat from that of hopelessness, Gilbert and Allan (1998) carried out a multivariate analysis and found that defeat remained highly correlated with depression even after controlling statistically for the effect of hopelessness. Perceptions of social rank, as indicated by measures of social comparison and submissive behaviour were significantly intercorrelated and both were significantly associated with defeat and entrapment. Of interest here, was the sole gender difference to emerge from the study. Not surprisingly, given the data on gender development rankings discussed in Part One, the difference concerned social comparison. Not only male students, but also male patients had significantly higher scores on the social rank measure of social comparison than did females from both of these groups.

Thus, in pursuing the significance of emotional responses to events, Gilbert and Allan have confirmed the importance of very similar factors to those identified in the work of Brown and Harris and their co-workers.

Taken together, both lines of enquiry make a compelling case for the depressogenic effects of the severe provoking events and vulnerability factors that in turn appear to be strongly associated with women's subordinate social position.

Severe events and rates of depression

Additional evidence of the gender specific nature of the humiliation and defeat linked to the onset of depression in women is found in the work of Broadhead and Abas (1998). This study is also significant because it was carried out in Harare, the capital of Zimbabwe, rather than in the context of a developed, industrialised country. It offers a useful cross cultural comparison for assessing the relevance of the theoretical factors found to be important in the British research. It also provides evidence on the strength of the relationship between the nature and frequency of severe events and associated rates of depression. Broadhead and Abas (1998) studied 172 women randomly selected from a Zimbabwean township. They used a modified version of the LEDS and measured depression and anxiety with the Shona Screen for Mental Disorders. 30.8% of the women were diagnosed as having had a depressive or anxiety disorder during the previous year.

A previous study in Zimbabwe (Abas & Broadhead, 1997) reported an 18% annual incidence of depression, double that found in inner London. In accounting for the much higher rate again in the most recent study, Broadhead and Abas (1998) attributed the excess of onset cases in the study year primarily to the increased numbers of severe and disruptive events and difficulties occurring in these women's lives. Furthermore they found that a proportion of the severe events experienced were more threatening those that have been described in the British research.Their main findings also confirm that certain types of severe events are especially depressogenic. Such events typically involve a woman's humiliation, her entrapment in an ongoing difficult situation or the experience of bereavement. Broadhead and Abas (1998) include a number of descriptive vignettes in their paper to illustrate the circumstances and situations on which their coding of severe events was based.

In what follows, three cases are reproduced verbatim for illustrative purposes. The first two cases received a higher severity rating than had ever been used in studies carried out in the UK in order to accurately reflect the severity of the threat related to the events experienced by women in Zimbabwe. The third case involved a severe event rated as humiliating.

Case 1: Severe threat

Subject is aged 43, married with nine children. She works informally roasting maize cobs to sell at beerhalls. The family could just afford basic food and government schooling costs. The event is her husband's death. His company refuse her access to his pension unless she can persuade a male elder from his family to claim it. His family live 200 miles away and she has no money for the bus fare. The children are dismissed from school for non payment of fees. They are living on one small meal a day.

Case 2: Severe threat

The subject is aged 40, is the second wife in a polygamous marriage. Her 9-month-old baby has just died after a long illness and her husband has early AIDS. Over the next 10 days, she is beaten by him and given a black eye, obvious at the funeral. She is excluded from traditional healer consultations at which she is blamed for causing the child's death through negligence.

Case 3: Severe event rated as humiliation

The subject is 43, happily married for 26 years. She lives between Zambia, with her four children and Harare, where her husband's business is. The event is returning to Harare to find her husband living with a young woman. She is forbidden entry to her own home and has to return to Zambia.

In all the cases described, the gendered nature of the severe events is conspicuous, although not specifically commented on by the researchers. They do, however comment on the salience of extreme loss, powerlessness, humiliation and entrapment. Yet in each case quoted, some form of gender-based discrimination and the

perpetration of an injustice clearly exists, for which the woman has no seeming recourse precisely because of her powerlessness as a woman living in that particular set of social circumstances. In all four cases, it is the use of male power to humiliate and exclude that is pivotal in defining the events that provoke depression. Applying Gilbert and Allan's model, this power is employed in order to reinforce the woman's subordinate rank and to create a situation of 'blocked escape.'

Overall, 94% of onsets in Harare were found to be preceded by a severe life event. The population attributable risk was 0.89, that is 89% of cases had a severe event of aetiological importance. Once major difficulties were taken into account this estimate increased to 94%. All but three of the events were found to involve humiliation or entrapment. Many of the severe events in Harare were reported to reflect, '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.' (p37) Such severe events would be predicted to increase in the context of rapid economic changes and rising income disparity and economic inequality that further weaken women's economic position and make survival more arduous. As noted previously, research conducted in four countries undergoing restructuring, namely India, Zimbabwe, Chile and Brazil showed that women, especially those with low education and living in poverty were more likely to develop depression, anxiety and somatic symptoms in response to increasing social and income inequality (Patel et al, 1999). Moreover, depression is likely to persist longer when it co-exists with economic deprivation (Patel et al, 1998).

It is interesting to consider the cases from Broadhead and Abas's (1998) work and to examine them in the light of Nolen-Hoeksma's (1987) theoretical perspective. Nolen-Hoeksma favours the view that women have an increased vulnerability to depression because their response to it is characterised by passivity and rumination.

Piccinelli and Gomez Homen (1997) commenting on this explanation go on to say that:

> ***'Relative to an active response set, a ruminative response set for depression may amplify depressive episodes by interfering with instrumental behaviour, by leading to failures and a sense of helplessness, by facilitating the accessibility of negative memories and by increasing the chances that an individual considers depressing explanations for his or her depression.' (p52)***

The chief difficulty with this interpretation is its apparent assumption that response sets operate independently of actual events, that their contents are not developed or formed by contact with the objective realities or social mentalities outlined here and that men and women live in a kind of 'even playing field' of life where both enjoy the same possibilities for autonomous action, unless inappropriate response sets prevent them from exercising instrumental behaviour.

However, more than 25 years ago, Pill and Stott (1982) found in their investigation of concepts of illness causation and responsibility for health amongst working class British women that notions of control were closely connected to actual social

circumstances. Perceptions of individual control of health were found most frequently among those buying their own house, in paid employment and with higher levels of education. This suggests that current social circumstances and experiences strongly configure individuals ideas about what can and cannot be controlled in their lives, including their health.

It is also critical to establish the temporal sequence of events if any attribution of causality is to be made. There is no doubt that depressed people feel a sense of failure and hopelessness, as much of the previous research quoted here makes clear. However, the presence at one point in time of a particular type of response set in common with the presence of depression, cannot illuminate causal sequence and is, of course, the main drawback of cross sectional studies.

The strength of prospective studies like those of Brown, Harris and their co-workers is that the temporal sequence and likely causal relationship between severe events and adverse psychological outcomes can be elucidated.

In the research of Broadhead and Abas (1998), it is interesting to speculate on the possible additional contribution to depression made by a ruminative response set in the case of the recently widowed mother of nine. This was the woman whose husband's company refused to give her the pension to which she was entitled, unless she could produce a male elder who lived 200 miles away, when she did not even have the money for the bus fare. Given that 94% of cases of depression in this study related to such severe events, the role of a ruminative response set seems minimal.

Moreover, the quality of blocked escape, apparent in this and the other examples, raises questions about exactly what actions were viable options for these women. The depletion of social capital and the blocked escape represented by low social rank and worsening income inequality have now been demonstrated to strongly affect both physical and mental health outcomes (Kawachi et al,1997, 1999; Patel et al,1999).

Before invoking explanations of depression as a function of a defective response set, it would seem essential to account for the constraints imposed by class and culture and to establish the presence or absence of genuine opportunities for action in the specific set of circumstances in which depression arises.

Summary

Most of the theories reviewed here, which utilise detailed analysis of the nature and meaning of depressogenic events, point very strongly to the overwhelming aetiological significance of severe events and life difficulties in the development of depression. Of particular importance are those events and difficulties characterised by loss, humiliation, entrapment and a sense of lack of control and inferior rank. Events of this type appear to predict depression in places as dissimilar as London and Harare. Evidence suggests that the vast majority of onsets of depression can be explained in this way. Taken together, the evidence and the social theories of depression described here, support Stein's (1997) view that perceptions of equity and equality - the meaning and symbolism attached to particular events and experiences - does reflect

where one stands in the scale of things, and strongly influences women's mental health.

While the research reviewed in this section has explored the subjective correlates of events related to subordinate status or lower rank, much previous research has documented the relationship between various objective measures of rank and the increased likelihood of depression and anxiety. Low educational status, unemployment or low employment status, homelessness and insecure housing tenure, inadequate income and poor social support including unsatisfactory interactions with neighbours and relatives have all been found to be associated with increased rates of depression and anxiety and often interact with one another in reciprocal relationships (Goldberg et al., 1990; Belle, 1990; Pill, Peters & Robling, 1993; Ustin & Sartorius, 1995). There is some evidence that the social factors involved in recovery or restitution may differ from those implicated in the onset of depression and anxiety (Goldberg et al., 1990).

The research reviewed has identified factors which are protective against depression. In particular, the evidence suggests that having sufficient autonomy to exercise some sense of control in response to severe events reduces the likelihood of depression developing. Access to adequate material resources is also needed to underpin the possibility of making choices when confronted with severe life events. The presence of support when needed from a core tie in these same circumstances is also powerfully protective.

In summary, social capital, psychosocial resources and the wherewithal to exercise choice and have a sense of control over one's life appear critical bulwarks against depression regardless of a woman's age. In a Spanish study (Zunzunegui et al., 1998), for women over the age of 65, the same factors of social and emotional support, having a confidant, social activities and a sense of control over life, have been found to be just as important as for women of childbearing age in decreasing the risk of depression. Henderson et al's (1999) Australian study also demonstrated that not having serious shortages of money was related to lower rates of depression in older people.

Current research thus suggests that the effective promotion of women's mental health would attempt to meet the following objectives:

- To assist women to increase control over the determinants of their mental health, and in particular to work to eliminate any situations in which devaluation and discrimination might occur

- To decrease exposure to risk factors which erode or compromise health through education and changes to policy and legislation that will actively improve women's material well being, status and available life choices

- To involve women in decision making, not just in health treatments or interventions but also in events and decisions which affect their lives and health more broadly

- To ensure any treatment directed towards women's mental health is obtained on the basis of informed consent and guarantees dignity and confidentiality

- To strengthen social networks and communities that can provide practical and emotional support

- To preserve and strengthen social capital, as a public good, and reduce income inequalities by ensuring mechanisms are maintained which allow equitable distribution of income in the context of 'privatization' and economic restructuring.

PART THREE

POVERTY, SOCIAL POSITION AND MENTAL HEALTH

Relationship between social class and mental health

One of the most consistent findings of epidemiological research is the relationship between low socioeconomic status or social class and increased rates of mortality and morbidity (Townsend & Davidson, 1982; Macintyre, 1986; Dohrenwend, 1990, Arber, 1991; Arber 1997). A more than a two-fold increase in risk has typically been found for those in the lowest social class compared with the highest, for psychological as well as physical morbidity. (Neugebauer, Dohrenwend & Dohrenwend, 1980; Helzer et al., 1986; Dohrenwend, 1990; Kessler et al., 1994)

For instance, in the 1980's, Helzer et al (1986) summed data across all five research sites involved the very large US Epidemiologic Catchment Area (ECA) study and found that the six month prevalence of any DSM-111 disorder was 2.86 times higher in the lowest socioeconomic status category than in the highest, controlling for age and sex. Dohrenwend (1990) in his review of those studies that had utilized the rigorous and explicit diagnostic criteria of DSM-111, RDC or Feighner, concluded there was compelling evidence of the relationship of SES and certain psychiatric disorders, namely schizophrenia, major depression, anti social personality disorders and substance abuse.

In this decade, in the US National Comorbidity Study, Kessler et al. (1994) utilizing a revised version of the Composite International Diagnostic Interview (CIDI) with a total sample of 8098 respondents, found that for lifetime prevalence, those in the lowest income group were 1.56 times more likely to have an affective disorder, twice as likely to have an anxiety disorder, 1.27 times more likely to have a substance use disorder and 2.98 times more likely to have antisocial personality disorder than those in the highest income group.

Like the previous research, this study found that women had markedly increased rates of affective disorders, with the exception of mania, and also had increased rates of anxiety disorders. For any affective disorder, the lifetime prevalence was 23.9% for women compared with 14.7% for men and for any anxiety disorders, the corresponding figures were 30.5% for women and 19.2% for men. Also consistent with the findings of previous studies, men were found to predominate in diagnoses of substance use disorders and antisocial personality disorder. When any National Comorbidity Survey (NCS) disorder was counted, the lifetime prevalence rates for men and women were similar but higher than previously thought, with 48.7% of men and 47.3% of women meeting diagnostic criteria for any one NCS disorder.

The female excess in psychological distress and morbidity has been found consistently across the life span but for a number of physical symptoms and conditions, this female excess has been found to be less apparent or sometimes even reversed (Macintyre, Hunt & Sweeting, 1996). Dohrenwend et al., (1992) have suggested that while social selection may account for the predominance of schizophrenia amongst the lower social

classes, that social causation is a more likely explanation for a number of non psychotic disorders.

Thus the relationship between low socioeconomic status and a high prevalence of psychiatric disorders has been subject to two quite different explanations. The first, holds 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. The second, which is consistent with the carefully contextualised research of Brown, Harris and co workers over the last twenty years, asserts that the relationship is better explained in terms of the greater environmental and psychological adversity which accompanies lower socioeconomic status and, in turn, produces high levels of stress and depression. Evidence related to this view is clearly more congruent with a social model of health. Yet good quality evidence on this relationship for women remains sparse for a variety of reasons. One general difficulty has been the lessening of research attention paid to social, structural analyses of psychological disorders.

Just over ten years ago, Angermeyer and Klusmann (1987) noted that there had been a shift in social research from an emphasis on societal level analyses of socioeconomic status (SES) to more micro-level, individual based analyses of stress experience. They expressed the concern that there was 'a possibility that social class issues may be simply ignored instead of elucidated by the new thrust toward stress research'.(p6)

Certainly, stressful events in women's lives have been shown to exert direct effects on the development of depression (Kendler et al., 1992). However, the explanatory potential of the concept of social class is far from being exhausted and much remains to be done in elucidating the relationship between social position and health outcomes (Dohrenwend, 1990; Berkman & Macintyre, 1997; Arber, 1997). To improve understanding, more theoretically informed analyses and more precise measures of SES are necessary that can identify which aspects are most closely related to health, human development and life expectancy.

Clearly, there is a need to go beyond the 'facts' of the documented association of SES and mental health, where SES is crudely operationalised 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.

A more integrated theoretical understanding is a priority. Arber (1991) argues convincingly that the insights derived from role analysis, typically used to analyse women's lives, must be integrated into a structural framework. In other words, thinking has to reflect the fact that women inhabit both a public as well as a private sphere and that these spheres of activity interact with one another. According to Arber (1991):

> ***'Women's paid employment should be examined both as an additional role, which may result in additional stresses from the role demands of being a housewife, responsible for childcare and a paid worker in the labour market, and as a structural variable relating to women's own position in the labour***

market, her command over financial resources and as influencing her and her family's life style and life chances' (p426).

In a later analysis of data from the 1991 and 1992 British General Household Survey, Arber (1997) found a number of distinctions in health outcomes that related to particular aspects of women's social position and which underlined the importance of conducting separate analyses of educational qualifications, occupational class and employment status for both men and women. For example, while occupational health and employment status were key structural factors associated with limiting long standing illness for both genders, educational qualifications were revealed to be especially good predictors of women's self assessed health (Arber, 1997).

Measurement of women's socio-economic status (SES)

With certain exceptions, such as the work of Arber (1991, 1996, 1997) the supposedly simple 'facts' of women's socioeconomic status or class are not well ascertained or measured. The reasons for the lack of relevant facts illustrate how even 'hard' data like rates are socially constructed and expressive of gender differences in social arrangements. These differences serve to challenge the assumption that common measures of socioeconomic class are gender neutral.

Problems in measurement include whether a woman's own or her partner's occupation, if she has one, should to used as an indicator of her social class. Unemployment, if defined as not being in paid work, may have quite different connotations for women than for men. These may arise from differing conceptions of role and identity which influence whether or not unemployment is perceived as the deprivation of a primary role and the primary source of income. Women who are not in paid employment, but are caring for small children or other adults, doing productive but unpaid work in the home and possibly undertaking training or study, may or may not feel un or underemployed in this sense.

For the measurement of income dual difficulties exist. First there is a difficulty in obtaining adequate information regarding income and second, a problem in determining whether a woman's individual income is a reliable measure of her social class. Macran, Clarke and Joshi (1996) in their analysis of health and socioeconomic data from 3746 working aged women taken from the British Health and Lifestyle Survey reported that information on income was missing for 22% of the sample overall and for 51% of women living in 'complex' households consisting of a number of unrelated people.

The use of incomplete data, cannot result in accurate or valid estimates of women's income and may be partly responsible for the weaker relationship reported so far between income and health for women compared with men. If significant gender differences in the comprehensiveness of income data are common, then reports comparing men's and women's incomes are not comparing like with like. When a significant amount of data on key socioeconomic variables like income is missing, it behoves researchers to report this as Macran, Clarke and Joshi (1996) have done. If such an acknowledgement is not made, the implication is no problems of this kind exist and that the finding of a statistically weaker relationship between income and health for

women compared with men, can be taken at face value rather than possibly reflecting poor measurement and ascertainment of women's income.

Further, it would not be surprising if this gender difference in the adequacy of data biased subsequent interrelationships between income and other health related variables. Large sample sizes typical in epidemiological prevalence studies cannot ameliorate such an inadequacy, indeed the larger the sample the larger the systematic bias from this source might be.

Similarly, using household income (even if it is available) in both 'complex' and even in 'traditional' families can be misleading, unless additional information is collected for interpretive purposes, on how the income of the household is distributed. When household income is solely or mainly income from male earnings, some women may not even know the income of their household, unless they are specifically informed. Indeed, the sharing or otherwise of such information may, in itself, be a significant indicator of control over access to other forms of information and resources, exercised along gender lines within the household. Furthermore, if women within certain households have little or no income under their control, their poverty will remain invisible (Shaver, 1998).

Macran, Joshi and Clarke, (1998) also found that variations in health outcomes for women were strongly predicted by differences in their types of employment. They argue that the potential predictive power of these occupational differences for health cannot generally be accessed because of the narrow grouping of women's occupations in standard measures of occupational status and suggest that these should be changed. Difficulties in the measurement of income have also been reported in developing country research. Patel et al (1999) noted that in Goa, India, women's personal income could not be used because many of the women in their study were not involved directly in income generation. Instead, the 'proxy' measures of whether the person was in debt and had been unable to buy food due to lack of money in the last month were chosen.

Given these problems in the accurate ascertainment and measurement of 'hard' socioeconomic indicators as well as other even more complex influences on health, it is not surprising that Shadbolt (1996) reporting on women's life course using data from the Australian Family Project concluded that:

> ***'These findings suggest that the influence of society's social structures on health for women goes beyond causes related to conventional socioeconomic differentials'***

Yet, it is only on the basis of accurate information regarding women's social position that a fruitful psychosocial inquiry can be made into why there is a higher prevalence of certain mental health disorders such as depression among women. An additional task is to identify precisely those factors which determine the patterning or variation of psychological morbidity within, as well as between, women from different socioeconomic groupings. Before commenting on research findings related to women's mental health, the importance of gender differences in risk factors for poor health outcomes in general, needs to be underscored.

Existing evidence suggests that some health risk factors are different for men and women while others are the same but differ in the strength of their effect. Unfortunately,

gender is rarely considered as a structural determinant of health and studies looking at the role of gender using such a framework are relatively few. The findings of three studies, one Australian (Weston, 1996) and the other two British (Arber, 1991) will be used to illustrate the kind of differences found so far.

The 1993 *Australian Living Standards Study: Box Hill Report* (Weston, 1996) analysed which risk factors, including behavioural risk factors, were associated with poor self rated health for men and women who were parents. Perceived unwellness for both parents was related to the reporting of an intermediate or serious illness or disability and speaking a non English language at home. The language spoken at home also related significantly to unhealthy lifestyle patterns and health risks for both genders. Unhealthy lifestyle patterns were more common amongst those who did not have a tertiary degree, were blue collar workers and had a low household income. It goes without saying that there is a high degree of intercorrelation between these factors. Having a sense of inertia was predictive of poor self perceived health for men, but not for women. For women, three further factors were significantly related to women's perceived sense of unwellness. These were smoking, being a teetotaller and reporting relatively limited physical exercise during leisure. Such behavioural health risk factors also varied within and between different groups of women. For example, single mothers were more likely than other mothers to smoke cigarettes.

In Arber's (1991) analysis of data from the 1985 and 1986 *General Household Survey in Great Britain*, significant differences as well as some similarities in the variables associated with health inequalities were also found for men compared with women. Health inequalities for men were primarily associated with unemployment, occupational class and to a lesser extent living in local authority housing. These same structural variables and their associated disadvantage were even more strongly correlated with poor health status for women. Thus non paid employment (both being a housewife or being unemployed), low occupational status and living in local authority housing were all correlates of poor health status. In addition, marital and family role variables were important for women including being divorced, separated or widowed and having dependent children. The exact configuration of these relationships also appears to be life stage and role dependent. Shadbolt (1996), in another Australian study, using life course data concludes that the relationships between socioeconomic factors and women's health are dynamic and complex, reflecting the fact that women's social role careers are cumulative and interrelated.

Arber's analysis of 1991 and 1992 data from the General Household Survey revealed some additional interesting gender differences relating to health and social position. For example for two measures of ill health, namely limiting long standing illness and self reported health, occupational class was a stronger predictor than educational qualifications for men and of long term illness for women. Women's limiting long term illness related only to their own labour market characteristics, whereas for self reported health other aspects of women's lives were significantly associated. These included their household material conditions and for women who were married, their partner's occupational class and employment status (Arber, 1997). Similarly, class inequalities in health were found to be greater for non employed compared with employed men, but weaker for non employed than employed women. Given the increasing proportion of the population that is not currently employed, Arber (1996)

recommends that research into health inequalities must include non employed people in analyses using their last main occupation.

Behavioural risk factors, physical and psychological comorbidity

Women's higher rates of illness, poorer self rated health and higher burden of common mental disorders make it critical to address the role that social position plays in this burden of morbidity. Undoubtedly, the highest rates of ill health and morbidity occur amongst women living in the most socioeconomically disadvantaged circumstances (Blaxter, 1990; Arber, 1991; Popay, Bartley & Owen, 1993; Weston, 1996; Arber, 1997).

While the focus of this report is necessarily on the psychological morbidity and comorbidity experienced by women, this artificially separates mental from physical health. From a health promotional perspective, there is an urgent need to address the high level of comorbidity existing between physical and psychological ill health, negative health behaviours and socioeconomic disadvantage (Macran, Clarke & Joshi, 1996; Elliott & Huppert, 1991).

Smoking

Smoking is a good example of these complex interrelationships. On one level, smoking can be approached as a single behavioural risk factor that is a highly preventable cause of ill health. However, smoking rates are highest amongst women experiencing the greatest social disadvantage and such disadvantage is multifaceted and structurally embedded making it difficult for individuals to change either their social position or the health related to that position. In developed countries, the highest rates of smoking occur amongst women with the most socioeconomic disadvantage, such as single mothers (Stewart et al., 1996; Weston 1996). Smoking, in turn, is significantly more common amongst women who are depressed and have a history of violent victimisation (Acierno et al., 1996) and smoking typically coexists with a number of other high risk health behaviours such as drug and alcohol use and poor PAP smear attendance (Springs & Friedrich, 1992).

Evidence on women's smoking rates reveals a continuing high and apparently obdurate level of smoking, especially amongst socioeconomically disadvantaged women, and an increasing rate of deaths from lung cancer. Both coming from a lower social class household and having parents who smoked have been found to be associated with smoking for both young women and young men, while social class and gender were independently associated with young people's drinking (Green et al., 1991).

Differences in socioeconomic status were also found in a longitudinal study to be strongly predictive of differences in women's lung cancer mortality. However, consistent with the need apparent from other research to use accurate measures of women's SES, this study found that when husband's occupation was used as a proxy measure of married women's SES, it seriously underestimated the actual extent of social differences in lung cancer. On the other hand, when an alternative measure based on

housing tenure and car access was used, the socioeconomic differences were wider than previously recorded for England and Wales. Married women living in rented housing and without access to a car were two and a half times as likely to die from lung cancer as women living in owner occupied housing with access to a car. Similar socioeconomic differences were found in smoking patterns, uptake and cessation rates over two time periods (Pugh et al., 1991).

Yet much health promotional activity around the reduction of smoking rates in women ignores the relationship between smoking, violence and socioeconomic status, and appears to conceptualize smoking as a primarily individual, modifiable risk behaviour whose change can be best achieved by bringing graphic information on the health effects of smoking to the attention of individuals, as if they lacked any awareness of the connection between smoking and lung cancer, heart disease and low birthweight.

The failure of this health promotional approach suggests another model of why women smoke and how and under what circumstances they might quit is urgently required. Acierno et al (1996) assert that it may be useful to conceptualise smoking as a strategy to cope with negative affect. The findings of their study certainly support this view with women who smoke having significantly higher odds of having a lifetime history of assault and a previous history of depression or post traumatic stress disorder (PTSD) than women without such factors.

As Evans (1994) has pointed out, if behavioural factors like smoking are connected to social circumstances, then the negative impact of smoking is unlikely to be significantly reduced without acting independently on those circumstances. Therefore low income, and a history of depression and/or violence, at the very least, need to be considered as additional risk factors.

Need to link physical and mental health

The focus on women's reproductive health, as noted in Part One has limited the research attention paid to other conditions, their interrelationships with one another and how their prevalence is patterned by social position. But even with research conducted on reproductive health, the interrelationship between physical and psychological well being has not been sufficiently investigated. In one study (Brown et al., 1994), where a strong relationship was found between high scores for the impact of negative health events and rates of depression in women eight months after the birth of their baby, the researchers comment that:

> ***'This suggests that whatever influences the physical well-being of new mothers has an indirect but critical effect on their emotional well- being. So far, the relationship of physical health to emotional well –being following birth has been under-researched.' (p196)***

Another example of a potential highly significant relationship between physical and psychological conditions being ignored in research concerns cardiovascular disease (CVD) and depression. CVD is the leading cause of death in women and like depression is about twice as prevalent in socioeconomically disadvantaged women as

advantaged ones, but has received relatively little research attention compared with that dedicated to understanding CVD in men (Mastroianni, Faden & Federman 1994).

Musselman, Evans and Nemeroff (1998) examined all research studies on the link between CVD and depression over a thirty year period from 1966 and 1997. Most of these studies concerned men. Their review concluded that recent evidence pointed to increased cardiovascular morbidity and mortality in patients with depressive symptoms or major depression. The relative risk of major depression or depressive symptoms for CVD or CVD related death ranged from around 1.5 to 4.5. The highest risk was related to a history of major depression and the researchers recommended that more research needed to be carried out to illuminate the interplay between central nervous system, platelet and cardiovascular processes. Given women's predominance in diagnoses of major depression, the relationship between depression and CVD is an extremely important one. The researchers concluded that:

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

Throughout the world, women have a lower level of development than men. None of the 146 countries for which a Gender Development Index (GDI) was calculated had a higher GDI than Human Development Index (HDI) (UNDP, 1997). Thus, even with the measurement problems regarding women's socioeconomic status already discussed, the UNDP composite measure based on life expectancy, educational attainment and income, revealed that the burden of poverty and socioeconomic disadvantage across a range of countries at different levels of development, is disproportionately borne by women. More than 10 years ago, Kaplan et al. (1987) in a longitudinal study of depression reported that inadequate income for women was associated with an elevated risk of depressive symptoms over the nine year period of their study.

In addition to the generalised burden of poverty on women, there are certain groups who are over represented amongst those living in poverty. In developed, industrialized countries, five groups in particular are disproportionately likely to live in poverty (Najman, 1993). These are sole parents, the aged, the disabled, racial and ethnic minorities and the unemployed. Women predominate in two of these groups namely as sole parents and among the aged, and are the main carers of the disabled and the elderly. The assumption of such caring roles poses an additional risk of impoverishment. Moreover, as already noted, an increase in poverty is associated with a corresponding increase in poor health.

Women's greater exposure to poverty throughout their lives occurs for a variety of reasons including lower levels of education, receiving lower rates of pay, doing more part time work and 'casual' work and consequently, being less likely to be able to amass adequate savings or superannuation for a financially secure old age (Shaver, 1998). In turn, these factors are influenced by the way in which women's economic dependency is structured by their gender specific social and sex roles across the life span. Women are more likely to be economically dependent on men and have reduced earning capacity

because of their caring roles for children and others. The significant gender differential that exists in the level of parental responsibility and care for children, even between full time working parents, disproportionately impacts on women's use of time for alternative activities (Blaxter, 1990; Arber, 1991; Brown et al., 1994; Macran, Clarke & Joshi, 1996; Akerlind et al., 1996).

Whether the impact of poverty on women's mental health stems primarily from the fact that women are affected differently by poverty than men or children due to their different roles within families, and/or derives mainly from the fact that women are so over represented amongst people living in poverty has yet to be established.

The evidence on which the social theories of depression, discussed in the section four, are based, strongly suggests that occupying a low social rank limits access to material and psychosocial resources, interacts with the ability to exercise autonomy and decision making latitude over severe life events and increases the likelihood of experiencing humiliation and entrapment.

Since the 1970's, limited access to base material necessities and psychosocial resources have repeatedly been found to be associated with increased risk of depression. Low and uncertain income, homelessness, inadequate and insecure housing, single parent status, unemployment, unrelieved child care, low levels of education, lack of confidants, poor social support and unemployment have all been associated with increased rates of depression (Pearlin & Johnson, 1977; Brown & Harris, 1978; Pill & Stott, 1982; Makovsky 1982; Belle, 1982; Kaplan et al, 1987; Belle,1990; Najman, 1993; Brown, Harris, Hepworth, 1995)

Other obstacles, deficits and threats to health inherent in poverty which reduce autonomy and constrain decision making latitude include exposure to dangerous environments involving crime, violence and discrimination, especially for women who belong to minority groups, 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 counter productive coping behaviours undertaken to provide relief from stressful lives over which the women may have little or no control (Belle, 1982; Belle 1990; Evans, 1994; Stewart et al., 1996; Weston, 1996).

By contrast, healthy coping behaviours invariably require the investment of time, energy, knowledge, money and having real choices. It can be beyond socioeconomically disadvantaged women's perceived and actual capacity, for example, to be able to access psychological counselling, undertake regular exercise, afford nutritious food, take up preventive health behaviours or move to a safer living environment. Decision making latitude is further undermined for women who are 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 and frightening. The dependence created is likely to heighten feelings of powerlessness, lack of autonomy and a sense of worthlessness (Dennerstein, Astbury & Morse, 1993).

Moreover, Belle's review of studies, up to 1990, on the psychological effects of poverty, notes that poor women have been found to experience more frequent, more threatening

and more uncontrollable life events than the general population, including the illness and death of children and the imprisonment of husbands. On the basis of evidence available up until that time, Belle (1990) concludes chronic life conditions can be even more potent stressors than acute crises.

Chronic difficulties and acute crises

Recent research of the kind described already, has explored further the psychological meaning of events and investigated the likely mechanisms by which these trigger depression (Brown, Harris, & Hepworth, 1995; Brown, 1998; Allan & Gilbert, 1997; Gilbert & Allan, 1998; Broadhead & Abas, 1998). The evidence generated by such research serves to qualify Belle's earlier conclusion. More specifically, this evidence suggests a more complex process is involved in the development of depression than can be attributed in an either/or sense to chronic difficulties or acute crises. Indeed, the very distinction seems to be misleading because it obscures the aetiologically important process of the 'matching' of current severe events to chronic difficulties that is necessary for the onset of most cases of depression (Brown, 1998). Related research on poverty suggests that a spiralling effect is involved in the interrelationships between poverty, poor health, especially poor mental health, unemployment and low income that cumulatively compounds their individual effects (Smith, 1996). Moreover, there is now sufficient good quality evidence to be confident of the nature of the relationship between the severity and frequency of severe events and depression.

Brown (1998) provides an overview of six population studies that all utilized the same semi structured interview measures- the shortened Present State Examination (PSE) (Wing, Cooper & Sartorius, 1974) and the Life Events and Difficulties Schedule (LEDS) (Brown & Harris, 1978, Brown & Harris (eds), 1989). The use of the same measures eliminates problems that otherwise make comparisons between studies problematic. As noted earlier, the studies took place in London (2), Harare, the Outer Hebrides and the Basque Country (2, one with Spanish and the other with Basque speaking women). Evidence from these studies shows a ten fold difference in depression over 12 months between the lowest rate, 2.5% in a rural Basque speaking population and the highest, 30%, in the black urban population of Harare.

The unequivocal significance of the occurrence of severe humiliating, entrapping 'irregular' events is all the more compelling because 'regular' events defined as life transitions found in all populations such as death or serious illness occurring at an expected age, were omitted from analysis. The studies thus confirm that it is 'irregular' events or those that bring about significant disruption to life and actual as well as symbolic losses of cherished beliefs, that are pivotal in the development of depression. Such 'irregular' events might include assaults, a husband's job loss due to heavy drinking, shocking revelations about someone close and marital separations. Rapid change and plunging living standards related to the kind of social and economic crisis and dislocation occurring in Russia and many parts of Asia deliver 'irregular' disruptive events on an unprecedented scale. On the other hand, this emphasis on 'irregular' events seems to imply that regular events and the preexisting pattern of life is non contentious in the development of depression. However, the 2:1 ratio of depression in women compared with men strongly suggests that what might be called normative inequality must be examined using a gendered analysis.

In countries with a high prevalence of HIV, women can experience terrible physical and psychological suffering, rejection, discrimination and blame for the disease (Long & Ankrah, 1996). It goes without saying that both the illness and the ill treatment it invokes will be associated with emotional distress and depression. The vignette reproduced in the previous section regarding the mother whose 9 month old baby has died after a long illness and who experiences both violence and blame for the baby's death from her husband who has early AIDS (Broadhead & Abas, 1998) is but one example of a phenomenon being experienced by countless women whose lives are being devastated by the epidemic.

Summary

It is now apparent that a highly significant, positive linear relationship exists between severe, humiliating, entrapping events and the prevalence of depression.
This relationship is especially evident in the very high rates of mental disorder found amongst homeless people up to a third of whom have been found to suffer from severe mental illness (Burdekin, Carter & Dethlefs et al, 1989; Tessler & Dennis, 1989).

Homelessness, is an increasingly prevalent social problem in developed countries. Precise figures are hard to obtain because conventional methods of counting people are based on them having somewhere to live and the methodological problems of counting people without a fixed address are formidable (US Institute of Medicine, 1988).

Nevertheless it is obvious that the average age when becoming homeless is decreasing and approximately half are known to be women. The traditional view of homelessness in developed countries as primarily applying to older alcoholic men sleeping 'rough' or in night shelters is no longer accurate (Burke, 1998).

In O'Connor's (1988) study, cited in Human Rights and Mental Illness: report of the National Inquiry into Human Rights of People with Mental Illness (1993), 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.

Homelessness functions to exacerbate every stress and adverse psychological outcome which has been documented for women in general, including poverty, violence, both physical and sexual, exploitation and abuse, disenfranchisement, inequality and substance abuse. It can be argued that homelessness is a consequence of mental disorder - the social selection, downwards drift argument. Even if this were the case, there can be no doubt that homelessness is also synonymous with experiencing precisely those severe events that have been linked to increased rates of depression. Moreover, for women, homelessness often represents both an escape and a trap - an escape from a hostile, sexually or physically abusive household, followed by the trap of homelessness, where the same conditions and experiences are repeated.

Fisher et al., (1995) in a US study of women who had been homeless for at least three months in the previous year, who were interviewed at day and night shelters found extremely high rates of battery (91%), rape (56%) and mental distress together with having very small support networks. Significantly, 86% of these women had been battered prior to becoming homeless. Thus violence as well as pre-existing poverty, unemployment, the increasingly low affordability of housing especially on the private housing market and social and economic change, all contribute to generating homelessness (Burke, 1998).

Indeed, it has been suggested that the notion of homelessness needs to be extended to include those who are insecurely housed, whether this relates to security of tenure or personal security and safety (Burke, 1998; Shaver, 1998). Such hidden homelessness applies to women subject to domestic violence for whom physical shelter neither ensures nor is synonymous with safety and security, as encapsulated in the saying that 'A home is more than a house'.

Accommodation options for girls and young women who are homeless have been found to be more problematic than those for boys, and girls run a 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 (O'Connor 1988).

The precise nature of the psychological difficulties experienced by homeless women has been questioned in a way which underlines the difficulty of causal attribution in relation to mental disorder and homelessness. Bassuk, Rubin and Lauriat (1986) are critical of the diagnostic accuracy of certain of these disorders, especially the common attribution of personality disorder, to homeless women.

> ***'Personality disorder is a diagnosis of social dysfunction and does not take into account the influence of environmental factors extrinsic to the organisation of the personality such as poverty, racism, and gender bias.'***

Place, severe events and depression

The large variation in rates of depression between places evident in the studies reviewed by Brown (1998) as well as other large scale, inter country comparison studies (Ustin & Sartorius, 1995) also underscores the importance of social arrangements in determining likely rates of depression.

These findings together with evidence on the characteristic triggers of depression already discussed, sound a strong cautionary note regarding the depressogenic potential inherent in the pace and extent of major social and economic changes such as are currently occurring in many parts of Asia, Russia and Latin America.

Large scale social and economic shifts that increase poverty, reduce social cohesion and increase insecurity far beyond what has previously been experienced, will by implication, produce an increase in the number of 'irregular' events and serious losses, confronting individuals that may overwhelm their coping abilities. In particular, the loss of cherished beliefs regarding the link between effort, education, secure work and financial reward may be threatened for the first time for large numbers of middle class people.

In Indonesia, a currency crisis coupled with austerity measures associated with 'bailout' lending conditions by the International Monetary Fund, quickly led to rising unemployment and price rises for basic food and goods, the destruction of living conditions and great political and social unrest. In such circumstances slow won gains made in health and education are lost, with huge numbers of people experiencing what was described as a 'class plunge' moving from a life of comfort to one of need from one week to the next.

The humiliation, sense of blocked escape and the associated depression which accompany such a change is described by one Indonesian woman, who first became unemployed, then quickly ran out of things she could sell:

> ***'I cried. I tried to commit suicide. I wanted to escape from this world.' (Jordan,1998)***

The fast tempo of large scale social and economic changes, as noted earlier, has already been documented to correlate significantly with decreases in life expectancy in Russia (Walberg et al., 1998). It has previously been documented that unemployment was 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).

Clearly, it is not only individuals' coping capacities that are overstrained in such circumstances but also their social networks and the pressure they are under as a resulting of declining social capital (Blaxter, 1990; Evans, 1994; Kawachi et al, 1997,1999). Nearly ten years ago, Belle (1990) pointed out that social networks do not simply function as sources of social support, they can also serve as 'conduits' of stress. She asserted that poverty, in particular, imposes a considerable stress on women as individuals and on their families while at the same time attacking many potential sources of social support. Social structural factors and social inequality have been found to be particularly important determinants of women's health (Denton & Walters, 1999).

Women in difficult economic circumstances, whose relatives and friends are in the same position and vulnerable to an increased number of stressful life events, will be likely to experience considerable stress 'contagion'. That more negative life events and less social support is experienced by those who are more socioeconomically disadvantaged has been confirmed by a number of other studies (Turner & Marino, 1994; Stansfield, Head & Marmot, 1998).

In the context of childbearing, more negative life events, but no fewer positive life events, poorer partner support and a lower level of satisfaction with the support and

higher levels of stress associated with motherhood and a toddler with a 'difficult' temperament have been found to be highly predictive of depression in women two years after giving birth (Brown et al., 1994).

Core ties, identity and the ethic of care

It has long been clear from epidemiological prevalence studies that income levels predict depressive symptom level. For example, one earlier 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, Williams & Greenberg, 1985).

There is now a considerable body of evidence that paid employment is linked to good mental health for women. Moreover, undertaking multiple roles such as motherhood and paid employment which was initially feared to pose a threat to women's well being through the pressure exercised by 'role strain' or 'role conflict', has in general been found to favour positive psychological outcomes. Thus evidence has, in the main, supported the expansion hypothesis which holds that having multiple roles is more beneficial to women's health than having fewer roles (Verbrugge, 1983; Waldron & Jacobs, 1989; McBride, 1990; Macran, 1993).

However, this does not mean that parental status carries the same meaning for working women as it does for working men nor that women's parental status does not affect their decision to work part or full time or influence other aspects of work, including the extra leave that women may feel the primary obligation to take when children are sick (McBride, 1990; Akerlind et al., 1996). Whether or not women are in paid work, numerous time use studies report that they also do the vast majority of unpaid work in the home (Hochschild, 1989; Bittman, 1992). In other words, increased participation by women in the paid work forces has exerted very little effect on the gendered division of labour within the household.

The notion that the link between good health and employment attests to the healthy worker effect or that good health is a prerequisite for or invariable correlate of being in paid work (compared with being unemployed) does not always hold as far as women are concerned. One British study carried out in the 1980's, found that women who were under the age of 40 and in full time unskilled or manual work, actually reported much worse health than did their 'unemployed' or unpaid counterparts who were housewives (Arber, Gilbert, Dale & 1985). In developing countries, overwork has been cited by women in Ghana and Brazil as a critical determinant of poor psychosocial health (Avotri & Walters,1999; Rozemberg & Manderson,1998).

The challenge, to which research in this decade has attempted to respond, has been in going beyond the fact of the linkages between women's mental health status and different variables including income, employment, marital, parental and socioeconomic status, to better understand the processes or mechanisms underlying them.

Thus research has examined how, why, at what age and for whom, depressive symptom levels vary in response, not just to the presence or absence of various stresssors and supports, but their strength and perceived adequacy.

Evidence on how marital and parental roles interact with employment status to affect mental health in different groups of women has revealed that these relationships are far from uniform across social and economic groupings. Elliott and Huppert (1991) found that social class strongly mediated the health effects of full time work for women, such that better physical health was correlated with full time paid work especially for women with middle class husbands. For psychological health, however, it was the demands of women's parental roles which were most salient. Women who worked full time and had pre-school age children had the most psychological difficulties.

It is hardly surprising that both the nature of work, especially unskilled, high demand, low control work in terms of Karasek's model and an awareness of what doing this work signifies in a social ranking sense (Gilbert & Allan, 1998) should contribute to adverse health outcomes. Similarly, it comes as no surprise that these effects, in turn, would be further modulated by the level of caring demands outside work, especially those associated with having the primary responsibility for the care of small children.

Thus two sources of identity and self-esteem are at stake for working women with children, either or both of which may constitute a core identity - being a worker and being a mother. Moreover the second one, has extremely high personal and social expectations regarding the exercise of an ethic of care, with women often setting themselves impossible goals about what they must do to be considered a 'good mother'. In one Australian interview based study, women were asked how they would describe a 'good' mother (Brown et al., 1994). The list of attributes was a long one, but three, in particular, were mentioned by many mothers. These were being caring and loving (38%) spending time with children (26%) and being patient (25%). Often these qualities were mentioned together, as evident in the following quotes:

> *'A good mum, I think is never-ending patience (laughs); spending a lot of time with them; loving, all that sort of thing.' (p142)*

> ***'A good mother is one who has time and patience for her children. Patience I think is the big key for children.' (p142)***

The issue of time availability may be especially pertinent for lone mothers who work full time. Time use and control over decision making have been studied extensively in the context of paid work. Such is the division in thinking and research about paid and unpaid work that mothering as a form of work has rarely been investigated using these concepts. One study which did examine parenting as work found that control , support and social gratification were significant factors in the development of depression six months after birth (Leathers et al 1997).

Macran, Clarke and Joshi (1996) in their analysis of data from the Health and Lifestyle study mentioned earlier, utilized subjective, objective, physical and psychological variables in examining the determinants of women's health. Their five dimensions of health included self assessed health, disease/disability, psychosocial health, illness and fitness. Their results confirmed the earlier findings of Arber, Gilbert and Dale (1985) regarding the poor psychosocial health of unskilled workers and factory workers. By contrast teachers had particularly good psychosocial health and professional women high levels of fitness. Women who were currently employed

had better health on all measures, not just psychosocial well being, than what were described as 'economically inactive' women and the researchers comment that 'whether the association between unemployment and women's health is cause or effect, it has a psychological dimension.' (p1209)

Married women with co-resident children were found to be healthier overall compared to those with no co-resident children. This relationship between having children and better health was also found for lone mothers however these mothers had poorer psychosocial health and more disease/disability and worse self rated health. Low household income was associated with poor health on all measures but significantly worse self rated health, psychosocial health and illness. An interesting finding was that while physical health measures worsened with age, psychosocial and self rated health measures actually improved with age, recalling similar findings by Mirowsky and Ross (1992).The worst psychosocial health of any group of women was that found in lone mothers who worked full time.

Amongst lone mothers, those who worked full time had even worse health than lone mothers who were economically inactive or unemployed, while those who worked part time had the best psychosocial health of all such mothers. Although the total group of lone mothers in this study was small (153 / 3746) both the better psychosocial health of those in part time work and the poorer psychosocial health of those in full time work (even after controlling for the effect of household income, employment status and occupation), suggest the need for further investigation with a larger sample size.

The poor psychosocial health of single mothers in general has been documented in earlier studies and like homeless women, over the last decade there has been a dramatic increase in the number of households headed by women, most of whom live below the poverty line and are dependent on government support (Belle 1988; Blaxter 1981; Trethewy 1989).As a consequence of this demographic change, poor psychosocial health, including depression, is likely to be occurring to an increasingly large proportion of the female population.

At first sight, the finding that lone mothers in full time work have the worst psychosocial health appears paradoxical, given that employment and higher income are both generally associated with improved mental health outcomes. However, women in this situation have to contend with the two sets of stresses, one associated with working full time and the other with having sole responsibility for childcare. They may also experience considerable personal loneliness.

There is a need to examine more closely why the health benefits which might be expected to accrue from the increased income associated with full time work are obliterated for lone mothers in full time work. Important losses, one of which is the loss of psychosocial well being, are obviously taking place in these circumstances and it is important to determine how the conditions of work can optimally and flexibly respond to the needs of women (and men) who also have responsibilities for children.

In terms of the sources of identity available to women as workers and mothers, the concentration of women generally and lone mothers particularly, in lower status, lower paid work, implies that self esteem as a result of work is unlikely (Macran, Clarke & Joshi 1996). In addition, by working full time, lone mothers are placed under severe

time constraints and this lack of discretionary time, in itself, may severely curtail opportunities for participation in social networks. The self esteem which might accrue from the identity of mother, is likely to depend on fulfilling expectations consistent with an ethic of care towards the child or children. Children, perhaps for lone mothers especially, will constitute highly emotionally significant 'core ties'.

The subjective psychological or symbolic meaning of severe, irregular events around humiliation and entrapment, was shown to be critical for the onset of depression in the work of Brown, Harris and co-workers, which has brought together strong research design, psychometrically sound measurement and in depth qualitative investigation of such events. Similarly, the meaning dimension of depression related to paid work and parenting, needs to be just as carefully articulated. Some essential elements that must be included in such a conceptually coherent account have already been identified (Arber, 1991; Arber, 1997; Macran, Clarke, Joshi, 1996; Berkman & Macintyre, 1997). It is not only the psychosocial and material resources and conditions under which women's work and parenting takes place that needs to be clarified. Beyond this more attention needs to be paid to the values, ethics and expectations that women, their partners and the broader society place on women's caring work and the satisfactions and dissatisfactions that flow from it.

Broadly speaking, however, there is now ample evidence that depression in many women is a predictable response to severe events and difficulties in their environment and with those with whom they have 'core ties', that evoke a sense of humiliation, entrapment and lack of control over life.

Social structural factors including low income and inequality are clearly one source of such events and such feelings. Another is the experience of violence. Both its prevalence and psychological consequences will be discussed in the next section.

PART FOUR

VIOLENCE AGAINST WOMEN

The problem

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

Violence represents a crucial violation of women's rights as human beings. The experience of violence necessarily violates women's rights to liberty and security of person and to freedom from fear. The presence of violence is incompatible with the enjoyment of the highest attainable standard of physical and mental health. For most of this century, scientific interest in the problem of violence against women and its links to poor mental health, has been negligible. However, the rise of second wave feminism and activism around women's rights engendered an upsurge of interest in the widespread social problem of violence against women (Walker, 1989). The extent of this problem has now been acknowledged. Violence against women is rightfully perceived as a priority health and human rights issue (WHO, 1997) and the United Nations has a Special Rapporteur on violence against women. In March 1999, at the 43rd session of the UN Commission on the Status of Women, a Resolution was adopted that recognized that violence against women is escalating in all cultures, societies and socio-economic groups and as a consequence the prevalence of mental disorders in women, throughout their life cycle, is also on the rise.

In 1992, the American Medical Association Council on Scientific Affairs noted that:

> ***Women in the United States are more likely to be assaulted and injured, raped, or killed by a current or ex-male partner than by all other types of assailants combined. (p3185)***

The National Comorbidity Study (Kessler, Sonnega, Bromet, Hughes, Nelson, 1995) confirmed that women compared with men had a greatly increased risk of being assaulted by intimates, although they had lower lifetime rates of physical attack. Of course, the problem of violence against women is much broader than the problem of physical attack.

That violence is overwhelmingly likely to be perpetrated by someone known intimately to the woman, is probably its most defining characteristic. It is certainly one that deserves special attention when seeking to explain the gender specific psychological impact of violence.

If the idea of having a home encompasses living in a place that affords physical and psychological safety and security, then a woman experiencing violence in her own home

is in a very real sense, homeless. Such a woman may have shelter, but she does not have a place where she can safely let her defences down. Violence in the home tends to be repetitive and to escalate in severity over time (American Medical Association, 1992). Violence can and does occur over the lifespan, from childhood to old age, with elder abuse being the most recent aspect of domestic violence to receive sustained research attention (Kleinschmidt, 1997). However, the peak incidence of physical and sexual violence occurs in young women (Australian Bureau of Statistics (ABS), 1996; Coyle Wolan & Van Horn, 1996; Acierno, Resnick & Kilpatrick, 1997; Fleming, 1997).

Violence at work is also emerging as a significant problem, although data is limited (Chappell & Di Martino, 1998). In 1993, workplace homicide in the US was the second leading cause of fatal occupational injuries overall, but the primary cause for women, with women working in health care at increased risk (Hewitt & Levin, 1997). American women ranked violence fourth in seriousness out of 11 hazards thought to affect female workers in a 1995 survey conducted by the US Bureau of National Affairs (Hatch & Moline, 1997).

Violence against women is perpetrated in 'peace' time in their own countries and their own homes, typically by those whom they know well and to a much lesser extent by strangers. In war time, violence often escalates when women become a particular focus of brutal, organised sexual violence by the opposing armed forces in their own country or from other countries (Littlewood, 1997).

For the first time, in 1998, a war crimes tribunal in Rwanda accepted that rape could constitute an act of genocide. Survivors of such violence must also confront the severe mental stresses associated with repatriation and relocation. In Bosnia, the multiple severe traumas experienced by women in these situations were predictably linked to very high rates of posttraumatic symptomatology (Dahl, Mutapcic & Schei, 1998).

Women and children are the first casualties in contemporary wars and are being deliberately targeted in armed conflicts. In recognition of this, the United Nations Children's Fund appealed for emergency aid, in January 1999, to help protect an estimated 48 million women and children in 20 countries endangered by war and other forms of violence and exploitation (Goshko, 1999).

Despite millions of women worldwide being caught up in wars, persecution and torture, most of the research on violence against women conducted to date, including that reported here, has been on 'peace' time violence. Relatively little research has been conducted on either the size of the trade in the trafficking and forced prostitution of women and children nor of its physical and mental health effects.

Terminology

The terminology used to describe violence against women varies from country to country. Some of the terms used include spouse abuse, wife abuse, intimate partner violence, gender based violence, sexualised violence, domestic violence and family violence. While there is no universally agreed upon terminology, broad agreement does exist about the interrelated elements that define violence. Characteristically, these

elements are highly congruent and sometimes identical with the features of depression previously described. For example, violence has been taken to include any act of verbal or physical force, coercion or life-threatening deprivation, directed at any individual woman or girl that causes physical or psychological harm, humiliation or arbitrary deprivation of liberty and that perpetuates female subordination (Heise, Pitanguy, & Germain, 1994).

Most instruments for detecting violence concentrate on the measurement of sexual and physical violence (Glander, Moore & Michielutte,1998) When physical or sexual assault by an intimate partner occurs within a context of coercive control, however, this almost certainly implies emotional abuse is occurring too (Campbell & Lewandowski, 1997). Indeed some have argued that partner abuse is best understood as:

> ***'A chronic syndrome characterised, not by episodes of violence, but by the emotional and psychological abuse used by men to control their female partners'. (Hegarty, 1998, p 5)***

However, these episodes of violence invariably succeed in producing emotional terror. One woman in an Australian study (Roberts et al., 1998) who had fled to another state and was using a false name, describes this effect:

> ***It's not the physical abuse which is worst but the terror which follows - the emotional abuse. I am still angry and terrified.***

Emotional and psychological abuse can also include manipulation, isolation from family and friends and intimidation as well as denigration and humiliation.

One of the most comprehensive definitions of violence was that presented in the Declaration and Platform for Action of the Fourth World Conference on Women in Beijing in 1995.

This states that:

> ***The term 'violence against women' means any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life. Accordingly, violence against women encompasses but is not limited to the following:***
>
> ***a) Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry- related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation;***
>
> ***b) Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution;***

*c) **Physical, sexual and psychological violence perpetrated or condoned by the State, wherever it occurs.***

Acts of violence against women also include forced sterilisation and forced abortion, coercive/forced use of contraceptive, female infanticide and prenatal sex selection.

The emphasis on practices such as forced sterilisation and prenatal sex selection and the singling out of 'traditional' harmful practices like female genital mutilation in the Beijing Platform has the inadvertent effect of implying that such practices might be confined to developing countries, where much health care is carried out by non professionals, or those in which 'traditional' values towards women's reproductive role are dominant or those where government policy regarding population control overrides the reproductive rights of individuals. This focus precludes examining the possibility that violent health care practices might be carried out in Western industrialised countries.

Violence in health care

Any health care practice that does not serve to protect women as patients from physical or psychological harm or coercion, regardless of the socio cultural and economic context in which it occurs or the level of training the practitioner has received, can and should be defined as constituting violence.

The most obvious example of psychological harm to patients is sexual misconduct by psychiatrists, psychotherapists and other doctors. Such misconduct constitutes a serious violation of the appropriate boundary between a professional and personal relationship. The psychological effects of these 'boundary violations' (Gabbard & Nadelson, 1995) include depression, anxiety, sexual disorders, sleep disorders, cognitive dysfunction, substance abuse, increased suicidal risk and prominent dissociative features (Kluft, 1989; American Medical Association Council on Ethical and Judicial Affairs, 1991; Leggett, 1995). In addition, the advent of evidence based medicine implies a commitment to the idea that what is done, should be done for the best possible reasons, according to the most rigorous scientific criteria for evaluating the efficacy of treatments and interventions.

The possibility that some existing health care practices may be violent and cause psychological harm must be considered. Of particular concern are those health care practices that persist despite evidence they are not efficacious; those that are carried out with greater frequency than is compatible with known risk factors for their use and especially those that result in psychological symptoms indicative of post traumatic stress and depression.

Reproductive health care, to which women are disproportionately exposed, deserves special scrutiny in this regard. One possible example needing further research is the high and increasing use of operative delivery in childbirth beyond the level recommended by the World Health Organization in a number of developed countries (WHO,1998).

In the last ten years, evidence that links caesarean section to negative mental health outcomes, including postnatal depression in the year following birth, has emerged from a number of studies (Green, Coupland & Kitzinger, 1990; Boyce & Todd, 1992; Hannah et al., 1992; Astbury et al., 1994; Edwards, Porter & Stein, 1994; Di Matteo et al., 1996; Fisher, Astbury & Smith,1997).

There remains a serious unmet need for research into the possible psychological harm caused by reproductive health care practices. For example, the routine practice of episiotomy still continues in many countries, despite evidence from randomized controlled trials that it is not efficacious in preventing perineal trauma (Klein et al., 1992; Harvey et al., 1996).

An attempt was made, for the purposes of this monograph, to examine research specifically carried out to investigate the possible psychological ill effects of episiotomy. The Medline search revealed no published papers. Similarly, only one paper (Bayoudh et al., 1995) could be located in peer reviewed research journals on the psychological impact of Female Genital Mutilation (FGM), even though this practice has affected an estimated one hundred and thirty million women worldwide (WHO, 1996).

If the research published in medical journals accurately reflects those problems considered important enough to warrant serious research attention, it would appear that the routine cutting of the female genitals is thought to be entirely unproblematic for women's psychological health.

Prevalence of violence against women in 'peace' time

Establishing reliable prevalence rates for violence against women, making comparisons between studies and accurately interpreting inter country differences in rates which have been found, can be affected by a variety of methodological difficulties and differences.

Methodological differences between studies can prevent direct comparisons of prevalence being made. For example, the operational definition of violence can vary from one study to another. Some studies measure lifetime prevalence, while others measure current violence only. Prevalence rates necessarily depend on the quality of ascertainment of cases which in turn is affected by the way women are questioned, such as face to face interviews or anonymous telephone or postal surveys and their perception of the level of confidentiality of their responses (Anderson et al., 1993; Campbell, 1998). Differences between studies in sample composition, including the age and marital status of those participating, are also important in determining the prevalence rates obtained.

Despite these caveats, a number of methodologically sound national surveys have been carried out in the last ten years. The World Health Organization's (WHO) (1997) review of studies, utilizing nationally representative samples of women in industrialized countries, Asia and the Pacific, the Middle East, Africa and Latin America and the Caribbean, found that lifetime prevalence rates of domestic violence ranged from a low of 16% in Cambodia and Mexico to a high of 42% amongst Kenyan women in Africa. The very wide variation in rates of violence against women in different countries suggests that potentially modifiable cultural factors play an important role in determining both actual rates of violence and attitudes towards its acceptability.

Ten years ago, Levinson (1989) in an ethnographic review of 90 peasant and small scale societies, identified four factors that were strong predictors of partner violence. These comprised economic inequality between men and women, a pattern of using physical violence to resolve conflict, divorce restrictions for women and the presence of male authority and decision making in the home. Importantly, some 16 societies in Levinson's study were classified as 'essentially free or untroubled by family violence.'
In the next section, the various forms of violence and their prevalence rates are described.

Physical partner violence

Physical violence towards women covers a range of actions of varying severity. These include slapping, punching, kicking, biting, burning and scalding, smothering, beating up or using a knife or a gun. As well as contusions, concussions, lacerations and wounds (knife and gunshot) physical violence from a partner has been found to result in high rates of ocular injuries (Beck, Freitag & Singer, 1995) and orbital fractures (Hartzell, Botek & Goldberg, 1996).

Punching tends to be directed to the head, face, neck, breast and abdomen. The findings of one hospital based study (Stark, Flitcraft & Frazier, 1979) underline the specific gender based nature of this kind of violence. Victims of partner violence were 13 times more likely than accident victims to sustain injury to their breasts, chests or abdomens. Physically abused or 'battered' women (compared with other women) are significantly more likely to rate their health as fair or poor, have higher rates of sexually transmissible diseases (STD's) and other gynaecological problems, more days in bed or off work and increased rates of health care utilization (Koss & Heslet, 1992; Resnick, Acierno & Kilpatrick, 1997). The psychological effects of physical violence will be discussed in a subsequent section.

Prevalence studies in a wide variety of cultures and countries indicate that from one fifth to one third of all women will be physically assaulted by a partner or ex partner during their lifetime (American Medical Association, 1992; Heise, Pitanguy and Germain, 1994; Australian Bureau of Statistics, 1996; Ellsberg, 1997). Annual incidence rates of physical violence ranging from less than 3% to 14% have been reported in a number of developed countries, including Australia, the United States and Canada (Australian Bureau of Statistics, 1996; Straus & Gelles 1986; Smith, 1987; Ratner, 1993).

Violence and reproductive functioning

Pregnancy appears to constitute a time of heightened risk for violence, with studies reporting rates from 4% to 41% depending on the population studied and the screening method used (Helton, McFarlane & Anderson, 1987; Koss & Heslet, 1992; Webster, Swett, Stolz, 1994; Norton et al.,1995; Gazmararian et al.,1996; Australian Bureau of Statistics, 1996). The level of violence during the postpartum period has been found to be even higher than in the prenatal period (Gielen et al 1994).

A comprehensive review of studies to the mid 1990's (Gazmarian et al., 1996) found that rates in most studies were in the range from 3.9% to 8.3%. In the national, Women's Safety Australia study (ABS, 1996) 42% of all the women who reported they had experienced violence at some time in their lives were pregnant at the time of the violence. Twenty per cent reported that violence occurred for the first time during the pregnancy.

Several studies have found that the abdomen is targeted more frequently and more severely in pregnant women (Koss & Heslet,1992; Parker et al, 1994; Gielen et al., 1994). Violence occurring during pregnancy is likely to inflict severe physical and psychological harm on the woman and the foetus. Women experiencing violence during pregnancy are more likely to have poor maternal weight gain, anaemia and infections, to give birth to a low birthweight baby and to smoke, drink alcohol and use other drugs (Parker et al, 1994).

Unwanted and unplanned pregnancies are increased amongst women living in violent situations. The coercive control exercised by a violent partner can extend to forced sex and preventing a woman from exercising her reproductive right to use birth control methods (Schei & Bakketeig, 1989; Heise, 1996). High rates of violence have been documented amongst women seeking terminations of their pregnancies (Evins & Chescheir, 1996; Glander et al., 1998).

Sexual violence in adulthood

Like physical violence, rates of sexual violence against women are disturbingly high but exhibit variation across cultures (Heise et al, 1994;WHO, 1997). The gendered nature of sexual assault is evident in findings from the American National Comorbidity Study (Kessler et al., 1995) The results of this study show that women face a disproportionately high risk of sexual violence compared with men. Lifetime prevalence rates of rape for women were 9.2% and rates for molestation were 12.3%. The corresponding rates for men were 0.7% and 2.8% respectively.

Other epidemiologically sound studies have reported that between 20% and 30% of adult women have experienced sexual abuse and assault during their lifetimes. As noted earlier, women are most at risk of assault from those known to them such as partners or ex partners and they represent the overwhelming number of rape victims (American College of Obstetrics and Gynecology, 1989; Koss & Heslet, 1992; Koss, 1994)
In one large US study investigating the impact of victimisation on women's health and medical use, Koss (1994) found that 24% of women interviewed had experienced crimes in which they were forced to engage in unwanted oral, anal or vaginal intercourse. In addition, 21% had experienced a completed forcible rape and physical assault separate from the rape.

Reactions to violence

Initial psychological reactions to sexual assault include shock, numbness, withdrawal and denial and these accompany physical responses such as lowered skin temperature, rapid heart rate, shaking and crying. Studies of the acute physical injuries following

completed rape have shown that both non genital injury and vaginal tearing are common. One study found that more than half the rape victims examined in emergency rooms had vaginal and perineal trauma and 15% had significant vaginal tearing (Geist, 1988).

Victims also face much higher risks of contracting sexually transmitted diseases including HIV (Irwin, Edlin, Wong et al, 1995). Although the risk of HIV is low in developed countries, fear of contracting the virus is a very significant source of concern to victims with up to 89% of a sample of recent victims in one study reporting such a fear (Resnick, Acierno, Kilpatrick, 1997). In countries with a high prevalence of the disease, such a fear would be entirely realistic. Two recent African studies found that more than 20% of women reported that their first intercourse was forced (Wood, Maforah & Jewkes, 1998; Chapko et al, 1999).

Sexual assaults can result in pregnancy. For example, Holmes et al., (1996) reported that 5% of women in a national sample of women with a history of rape had experienced a rape related pregnancy. It is likely that this figure is an underestimate given the under reporting of rape by women generally and the use of medication to prevent pregnancy amongst the minority of women who do report the crime in developed countries (Resnick, Acierno & Kilpatrick, 1997).

Child sexual abuse

In a comprehensive review of community studies on the prevalence of child sexual abuse, Leventhal (1990) found a wide variation in reported prevalence rates, ranging from 6% to 62%.

Different researchers use different definitions of child sexual abuse (CSA) and employ different age cut offs to define a child which affect the prevalence rates obtained. In addition the different methods of ascertaining whether abuse has occurred, such as in depth interviews compared with postal surveys and the use of brief general questions compared with more numerous, specific questions also affect the rates obtained (Martin et al., 1993). However, methodologically strong research, based on random, representative community samples suggests that around one woman in three has experienced unwanted sexual experiences before the age of 16 years (Beitchman et al., 1992; Anderson et al., 1993; Handwerker, 1993). For example, nearly a third of women from a randomly selected community sample of some 3000 women in New Zealand reported having one or more unwanted sexual experiences before the age of 16 years (Anderson et al., 1993). Most such experiences were serious assaults involving genital contact, intercourse or attempted intercourse and most of the perpetrators were known to the child. Other studies have also found that children are most at risk of abuse from family members and those known to them, who often occupy a caretaking role (Russell, 1983, 1986; Margolin, 1992; Yama, Tovey & Fogas, 1993). If a child is abused by a relative, the abuse is more likely to occur repeatedly and over a longer period of time, than if the abuser is someone outside the family (Russell, 1986; Brown & Anderson, 1991; Beitchman et al., 1992; Anderson et al., 1993; Fleming, 1997).

From time to time concerns have been raised about the accuracy and reliability of women's memories of childhood sexual abuse, especially 'recovered' memories. Two pieces of research are pertinent. Williams (1994) in an important study of 129 women

previously identified as child victims of sexual assault, found that 38% had no current memory of the earlier documented assault. Significantly, women who reported prior memory loss followed by later recall of the assault did not differ from women who had continuous memories in either elaborating or minimising the extent of the assault.

Elliott (1997) in a study on the recall of traumatic events such as natural disaster, witnessing violence and being a victim of violence, found that the severity of the trauma was predictive of memory status. A history of partial memory loss was reported in 22% of those who had been victims of either child sexual or physical abuse and complete memory loss occurred in 20% of victims of child sexual abuse. Complete memory loss was higher amongst victims of CSA than for witnesses of combat injury (16%), victims of adult rape (13%), and witnesses of domestic violence as a child (13%).

Of related interest are suggestive findings from a small study by Raskin (1997). Four groups were compared: those with mild traumatic brain injury alone, those with a history of sexual abuse, those with both mild traumatic brain injury and a history of sexual abuse and normal controls. Neuropsychological testing revealed that compared to normal controls, those with mild traumatic brain injury demonstrated deficits in working memory, those with sexual abuse had deficits in executive functioning, whereas those with both mild traumatic brain injury and a history of sexual abuse had deficits in working memory, executive functioning and memory.

A large body of research now attests to the association of CSA and a variety of physical, sexual and psychological problems in adulthood. Depression and anxiety are the primary psychological outcomes. It has been suggested that CSA may also be implicated in postnatal depression (Buist & Barnett, 1995; Buist, 1998). Psychiatric comorbidity is common. Markedly increased rates of depression and anxiety among women who have a history of CSA have been identified in community samples (Finkelhor et al., 1990; Bifulco, Brown & Adler, 1991; Mullen et al., 1988; Anderson et al., 1993) and psychiatric samples (Brown & Anderson, 1991; Pribor & Dinwiddie, 1992; Waller,1994).

The precise causative role of CSA in later psychological disorders is still being elucidated. Not least of the methodological difficulties involved in disentangling the contribution of CSA to later problems is the fact that it often coexists with other childhood factors that independently predict mental disorder in adult life. These include growing up in a disrupted, unstable home environment characterised by neglect, conflict and/ or mental disorder and by experiencing physical and emotional abuse at the same time as sexual abuse.

Factors that have been conclusively implicated in adverse psychological outcomes include the use of force and threats of force, penetrative sex, chronic abuse or revictimisation by another perpetrator or perpetrators and abuse by fathers and stepfathers (Browne & Finkelhor, 1986; Beitchman et al., 1992; Yama, Tovey & Fogas,1993). Evidence regarding the age at which abuse takes place remains equivocal. These factors may occur separately or act in concert with one another, for example, more than one perpetrator may be involved, and intrafamilial abuse generally takes place over a longer period than extrafamilial abuse.

Multiple forms of violence

Research on the prevalence of the various forms of violence perpetrated against girls and women points to a serious public health problem. Before examining the long term health consequences of violence, it is important to note that the different forms of violence described often occur together, thus exacerbating the traumatic potential of the experience. For example, physically threatening acts are often accompanied by verbal abuse, threats and by sexual violence as well (American Medical Association on Scientific Affairs, 1992). Thirty three to 50% women who are physically assaulted by their partners are sexually assaulted as well (Frieze & Browne, 1989; Ellsberg, 1997) and Coyle, Wolan and Van Horn (1996) found that 27% of the women in their study, reported all three forms of abuse.

The coexistence of emotional or psychological abuse with physical violence appears to be even higher. Ratner (1993) in a Canadian study reported that 93% of women who were experiencing physical violence also reported concurrent psychological abuse. In her study on domestic violence against women in Nicaragua, Ellsberg (1997) found that 94% of the women living with physical violence also reported verbal insults and humiliations, while 36% reported they were commonly forced to have sex while being beaten.

To explore violence from the perspective of abused women, Ellsberg employed narrative analysis to explore how women explained and interpreted the violence in their lives. This revealed that physical violence was so intertwined with psychological and sexual degradation that it was 'virtually indistinguishable'. The story of Ana Christina, one of the particpants in Ellsberg's study, is illustrative:

> ***When I didn't want to have sex with my husband he simply took me by force…When he came home drunk he would beat me, and do what he wanted with me. Then I fought with him, but what could I do against a man who was stronger than me? I couldn't do anything, so I had to put up with it and suffer. (Paper II, p 8)***

Revictimisation

Another factor compounding the likely psychological effect of violence is that of revictimisation. The phenomenon of revictimisation is an important consequence of violence in its own right and one that further complicates the complex task of understanding the long term mental health effects of violence when that violence is recurrent. One of the earliest attempts to identify reliable predictors of partner violence in adult life, was undertaken by Hotaling and Sugarman (1986). They identified 97 potential predictors of husband to wife violence. The only predictor to consistently correlate with whether a woman was a victim of partner violence was whether she had witnessed family violence as a child.

Women who have experienced violence in childhood are also far more likely to experience revictimisation than those who have not (Beitchman et al., 1992 ; Resnick et al., 1993). Women who have been victims of child sexual assault are two to four times

more likely to be raped in adulthood than non-victims, and are at heightened risk of experiencing other forms of victimisation (Russell, 1986; Simons & Whitbeck, 1991; Wyatt, Guthrie & Notgrass, 1992).

Amongst women with substance abuse problems, those who reported childhood physical abuse were found to be nine times more likely to report partner abuse and those who reported child sexual abuse were almost four times more likely to report partner abuse, than women who had not experienced abuse as children (Gilbert, el-Bassel, Schilling, Friedman, 1997).

For pregnancy related violence, women with a history of being battered are three times as likely as never battered women to be injured during pregnancy (Koss & Heslet, 1992).

Resnick and colleagues (1993) demonstrated the risk of experiencing an additional assault, even after controlling statistically for the effect of age, race, education and substance use, was five times greater for women who had already been assaulted. In women with histories of prior victimisation, rape is followed by particularly severe after effects (Sorenson & Golding, 1990).

Additionally, women who have been victims of incestuous sexual abuse in childhood and undergo psychotherapy are at increased risk of sexual exploitation by therapists and this revictimisation is followed by severe psychopathology (Feldmann-Summers & Jones, 1984; Kluft, 1989). Sexual misconduct by the therapist would be one reason why survivors of CSA have been reported to be unlikely to perceive mental health services as beneficial (Pribor & Dinwiddie, 1992; Morris, Martin & Romans, 1998).

In other words, revictimisation represents both an outcome of past violence and a risk factor for increasing the occurrence of and compounding the psychological effects of current or future violence.

Consequences of violence

A plethora of negative health consequences following all forms of violence - physical, sexual, emotional - have now been documented. As Calhoun & Resick (1993) observed:

> ***'It is now commonly accepted that the type of trauma experienced (although each has some unique features) is less important than trauma severity and individual reactions and vulnerabilities.' (p48)***

Women who have experienced violence, whether in childhood or adult life, have increased rates of depression and anxiety, stress related syndromes, pain syndromes, phobias, chemical dependency, substance use, suicidality, somatic and medical symptoms, negative health behaviours, poor subjective health and changes to health service utilization (Beitchman et al, 1992; Koss & Heslet, 1992; Koss, 1994; Fischbach & Herbert, 1997; Golding, Cooper & George,1997; Campbell & Lewandowski, 1997; Resnick, Acierno & Kilpatrick, 1997; Morris, Martin & Romans, 1998; Roberts et al, 1998).

Five dimensions of the problem of violence will be addressed here. First, features common to violence and depression will be outlined; second, evidence regarding depression and anxiety will be examined; third, research which has investigated the consequences of violence from the perspective of post traumatic stress will be discussed; fourth, issues raised by multiple health effects and comorbidity will be examined and finally, factors that can ameliorate the negative health consequences of violence will be identified.

Common features of violence and depression

The association between violence and depression and anxiety in women has now been well documented (Mullen et al., 1988; American Medical Association on Scientific Affairs, 1992; Gleason, 1993; Saunders, Hamberger & Hovey, 1993; Campbell, Kub & Rose, 1996; Campbell & Lewandowski, 1997). Given this association, it is of considerable aetiologic interest to examine features common to violence and depression, using the social model of depression described in Part 2.

To begin with, humiliation and entrapment which played such a prominent role in determining caseness for depression, are defining features of partner violence. Indeed, Ellsberg (1997) in summarising 25 years of research on partner violence concluded that:

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

The way in which constant denigration and humiliation enforce a sense of subordination and inferior social ranking and serve to diminish coping capacity is evident in the comment from one of the participants in Ellsberg's research:

> ***He used to tell me, "you're an animal, an idiot, you are worthless". That made me feel even more stupid. I couldn't raise my head. I think I still have scars from this, and I have always been insecure… I would think, could it be that I really am stupid? I accepted it, because after a point… he had destroyed me by blows and psychologically…. (Ana Christina, Paper II, p8)***

Similarly, the notions of loss and defeat as discussed by Brown and his colleagues (Brown, Harris & Hepworth, 1995), in their research on the development of depression in women, also figure significantly as psychological reactions to the experience of violence.

Violence involves loss and defeat on several levels - the loss of a sense of self and other (as previously imagined), the loss of a safe relationship and the loss of a cherished idea (being loved and unharmed).

In the context of an intimate attachment relationship and a role to which a woman is often highly committed and heavily psychologically invested, the cyclical, generally escalating nature of physical violence punctuated by acute battering incidents

corresponds to the matching of ongoing marked difficulty with a severe event (the acute battering incident). Brown, Harris and Hepworth (1995) contend that this is particularly likely to provoke a depressive disorder.

Psychological functioning is affected by alterations in the perception of the perpetrator, especially a belief in his omnipotence and alterations in a sense of self. Both self blame and loss of self are evident in Ana Christina's comments.

Violence, by forcing submission and enforcing inferior social ranking and subordination, engenders a sense of defeat and a loss of self esteem.

The psychological impact of violence may be seen to proceed from an experience of personal oppression (generally) within an intimate relationship which is reinforced and informed by a broader social context, where the unequal treatment of women remains normative. The gender development and empowerment rankings discussed in Section One of this monograph evidence this continuing practice.

Suicidal behaviour

Perhaps the most extreme form of psychological distress following violence is suicidal behaviour. The pivotal role of violence in such behaviour is becoming increasingly clear. It has been estimated that between one third and one half of all female homicide victims in the US have been murdered by their male partners, many after prolonged periods of victimisation (Kellerman & Mercy, 1995). One quarter of all suicide attempts by women in another study were preceded by physical abuse and in African American women this increased to half of all those who had attempted suicide (Stark & Flitcraft, 1996). In other countries, such as China and India high rates of suicide by women have been noted (Murray and Lopez, 1996) even though the precipitating role of violence may not have been fully documented.

In community samples of non treatment seeking women, between 17% and 19% of those who had been raped had made suicide attempts (Kilpatrick, Veronen & Best, 1985; Resick et al., 1989) Feelings of self blame, a heightened sense of vulnerability, isolation and mistrust of others are common.

If suicidal behaviour is placed within the context of violent victimisation of increasing severity up to and including murder, then it may represent to the battered woman, the only remaining escape from a situation of entrapment when all other forms of escape are literally and metaphorically 'blocked' (Brown, Harris & Hepworth, 1995; Stark & Flitcraft, 1996). In other words, entrapment, which plays such a critical role in the onset of depression, is a defining characteristic of violent relationships.

Depression and anxiety

Given these commonalities, it is not surprising that depression and anxiety are the most frequently documented, primary mental health responses of women to violence.

Controlled studies from a variety of settings have consistently found increased rates of depression and anxiety in women who have experienced childhood sexual abuse (Mullen et al, 1988; Bifulco, Brown, Adler, 1991; Pribor & Dinwiddie, 1992; Yama, Tovey & Fogas,1993) childhood psychological abuse (Ferguson & Dacey, 1997) and/or physical and sexual violence in adult life (Herman, 1992 ; Saunders, Hamberger & Hovey, 1993; Gleason, 1993; Campbell, Miller, & Cardwell, 1994; Ellsberg, 1997; Roberts et al., 1998).

Accumulating evidence suggests that the relationship between violence and depression and anxiety is causal, although a randomized controlled trial can never, for obvious ethical reasons, be carried out. One line of inquiry supporting this relationship comes from studies designed to establish temporal ordering. These studies compare the same women over time, ascertain levels of depression and anxiety at two or more points in time and quantify the extent to which changes in depression and anxiety in the interim are dependent on changes in the level of violence. Marked changes in rates of depression and anxiety have been demonstrated once the violence has stopped.

One study followed up women over time and found that those who were no longer being battered had significantly lower scores on the Beck Depression Inventory while those who were experiencing on going violence exhibited no mean differences in their depression over time (Campbell et al., 1994).

Recently, a study assessing women at three time points - immediately after leaving a domestic violence program and follow up eight and a half months and fourteen and a half months later, confirmed that ongoing abuse was significantly related to increases in depression and anxiety and physical health problems from one follow up period to the next. This relationship held even after prior levels of psychological and physical health were controlled (Sutherland, Bybee & Sullivan, 1998).

Another source of evidence comes from studies using community samples (rather than treatment seeking women) which have found significantly higher rates of depression and anxiety in those who have experienced one or more forms of violence compared with those who have not (Mullen et al 1988 ; Bifulco, Brown & Adler, 1991; Anderson et al, 1993; Ratner, 1993; Saunders, Hamberger & Hovey, 1993; Gleason,1993).

Not only are women who have experienced violence more likely to be depressed than those who have not, but in one study of nearly 400 women seeking care at a family practice medical centre, depression was found to be the strongest predictor of adult relationship violence (Saunders, Hamberger & Hovey, 1993).

Another way of assessing the strength of the relationship between violence and depression, anxiety and other adverse outcomes, is to establish whether the severity of the violence as a stressor is predictive of the severity of the outcomes which have been reported. The results of studies capable of examining the nature of this association clearly indicate that the severity of the stressor, (the violence experienced) is predictive of the severity of subsequent psychological disorders.

Revictimisation presents one means of examining severity. Women who have experienced violence in both childhood and adulthood as noted earlier have worse

psychological outcomes than those who have never been victimized and those who have been victimized once (Sorenson & Golding, 1990)

Not only do women who have 'ever' experienced violence differ significantly in their rates of psychological disorder from those never abused, but women who have been doubly or multiply abused have significantly higher rates again. This ordinal relationship has been found in studies on the mental health impact of domestic violence (Roberts et al., 1998) and of child sexual abuse (Bifulco, Brown & Adler, 1991; Mullen et al., 1993).

One methodologically strong study (Mullen et al, 1993) found that women who had experienced child sexual abuse (CSA) involving intercourse were sixteen times more likely to report psychiatric admissions than those subjected to lesser forms of abuse, and of all the women who reported a history of abuse, 85% had been admitted to a psychiatric unit or hospital at some time in their lives. CSA remained a significant predictor of later psychopathology even after all other factors were statistically controlled for that might account for this psychopathology. These included coming from an unstable family home where one or both parents were absent or themselves had mental health problems or a conflict ridden, unsatisfactory relationship. Mullen and his coworkers comment that:

> ***'This finding goes some way to explaining the high rates of childhood sexual abuse reported in samples from in-patient psychiatric units. Such abuse would appear, from this study, not only to be associated with increased vulnerability to psychiatric disorder, but also to make it more likely that admission will be required when disordered.'***

Self esteem is also significantly decreased by repeated abuse. Romans et al. (1995) that women who reported more than 10 abusive episodes of CSA had significantly lower self esteem than those with fewer abusive experiences. The relationship between severity of abuse and increased likelihood of psychiatric disorder is also supported by the differences in the type, frequency, duration and severity of abuse reported by women in studies using community samples compared with those using clinical samples.

In one large community study conducted in New Zealand (Anderson et al., 1993), 70% of abusive episodes lasted less than one year and generally took place between the ages of 8 and 12 years. By contrast, in one clinical study the average period of abuse was 12 years, nearly five different types of abuse occurred and more than two perpetrators were involved (Anderson, Yasenik & Ross, 1993) while in another clinical study the average duration of abuse was six years and had begun when the child was five years old (Nash et al., 1993)

There is some evidence that CSA may be more important than victimisation in adult life in accounting for the increased rates of depression in women compared with men. Whiffen and Clark (1997) compared women and men seeking out patient psychotherapy. Not only were the women more depressed than the men and more likely to have been victimized both as children and as adults, but only childhood victimisation accounted for a significant proportion of the gender difference in depression levels. Both sex differences in rates of depression and violence by intimate partners are substantial (Campbell, Kub & Rose, 1996).

The focus of the discussion so far, has been on depression and anxiety, but many other adverse psychological effects have been described in relation to violence. Depression and anxiety often co exist with other psychological disorders and with somatic symptoms, altered health behaviours and physical disorders.

Post traumatic stress

Post-traumatic stress offers a broader conceptual framework than depression from which to view the constellation of outcomes of violence against women. This framework can include depression and anxiety as co morbid disorders but post traumatic stress is not reducible to these disorders. Nevertheless, depression may be the most prevalent psychological disorder. For example, Gleason's (1993) study of battered women found a higher prevalence of major depression (63%) than of post traumatic stress disorder (PTSD) (40%). Unfortunately, comorbidity was not reported.

This finding is congruent with the broader literature on psychological responses to traumatic events where multiple diagnoses are commonly reported. Amongst victims of traumatic events who have been diagnosed with posttraumatic stress disorder, the commonest concurrent disorder is major depression (McFarlane & Papay, 1992). Additionally, high rates of anxiety disorders and substance abuse are common co morbid disorders (Calhoun & Resick, 1993).

Women who have experienced battering, sexual assault and especially those who have been raped, regardless of whether they are victim of stranger rapes or have been victimized by those they know, show many signs of persistent psychological distress. These include chronic fear, anxiety and depression as well as nightmares, sleeping disorders, suicidal thoughts and suicide attempts.

Many of the reactions women experience, such as intrusive re experiencing of the trauma, psychic numbing, avoidance of stimuli associated with the trauma and ongoing excess arousal and psychological distress, meet the criteria for a diagnosis of Posttraumatic Stress Disorder (PTSD).

The high incidence of sexual assault against girls and women has prompted some researchers to suggest that female victims make up the single largest group of those suffering from PTSD (Calhoun & Resick, 1993). A nation wide survey of rape in the US, found that 31% of rape victims developed PTSD at some point in their lives compared with 5% of non victims (Kilpatrick, Edmunds & Seymour, 1992). Epidemiological surveys in the general population have found that approximately 1 adult in 12 has experienced PTSD at any time in life and that between 15% and 24% of those exposed to traumatic events will develop subsequent PTSD (Helzer, Robins & McEvoy 1987). Women's risk of developing PTSD following exposure to trauma has been found to be approximately twofold higher than men's. Interestingly, this parallels the gender difference found for depression (Breslau et al., 1998).

Breslau and her co-workers (1998) in their epidemiological study of trauma and PTSD, found that PTSD persisted longer in women than in men and that assaultive violence including rape and sexual assault was associated with the highest risk of PTSD. While

assaultive violence had the highest probability of PTSD (20.9%), it was not the most common trauma. The sudden unexpected death of a loved one, an event experienced by 60% of the sample was the most common trauma but one with only a moderate risk for PTSD (14.3%). Women who have experienced domestic violence and sexual assault are at very high risk of PTSD (Lemieux & Coe, 1995; Letourneau et al., 1996; Kubany et al., 1996). Another study of Hawaiian women receiving services from several programs for battered women found that between 33% and 83% met diagnostic criteria for Post Traumatic Stress Disorder (PTSD) (Kubany et al, 1996). Rape victims have been found to be significantly more likely to develop PTSD than those who have not been raped (Resnick et al., 1993). Similarly increased rates of PTSD have been reported following physical assaults (Kessler et al., 1995). While the findings of Breslau and her coworkers suggest that PTSD persists longer in women than in men, there is evidence that physical symptoms do abate in the first year following rape.

In a prospective longitudinal study, 115 rape victims were followed up for one year and compared them with 87 women who had not been raped (Kimerling & Calhoun, 1994). The physical symptoms reported by rape victims, such as rapid heart rate, tension headaches, stomach aches, skin problems, menstrual symptoms, allergies and weight changes, did decrease over the course of the year and victims use of medical services was significantly higher than that of non victims at both 4 months and one year after the rape. By contrast, the psychological symptoms reported by victims remained significantly elevated over the whole year but they did not use mental health services significantly more often than non victims.

The assumption that trauma has ceased, inherent in the notion of 'post' traumatic stress disorder is not valid when considering chronic traumatisation or the cycle of violence described in relation to 'wife battering'. Judith Herman (1992) has postulated that a complex or chronic traumatic stress response is an even more accurate way of conceptualising the psychological effects of being subjected to ongoing abuse, control and terror than is the case with a single traumatic event. Similarly, Finkelhor and Browne (1985) has put forward a traumagenic model to explain the effects of child sexual abuse.

Comorbidity and the burden of violence

Just as the form which violence itself takes can be physical, sexual or psychological, so too, the health outcomes of violence can be manifested in physical, sexual and psychological disorders (American Medical Association on Scientific Affairs, 1992).

Existing evidence suggests there is a high degree of co morbid psychopathology and multi-somatisation associated with violence. Studies that have been designed to be able to make multiple diagnoses have found them but these have generally concentrated on either psychological or physical comorbidity but not both (Brown & Anderson, 1991; Pribor & Dinwiddie, 1992; Walker et al., 1995; Resnick , Acierno, Kilpatrick, 1997; Roberts etal., 1998).

Multiple somatic complaints, physical and psychological disorders and altered health behaviours have all been documented as consequences of violence. These include chronic pelvic and other pain syndromes, negative pregnancy outcomes, gastrointestinal

problems such as irritable bowel syndrome and inflammatory bowel disease, headaches, chronic fatigue and sleep pattern disturbances, pain syndromes, eating disorders, substance use disorders, post traumatic stress disorder, certain personality disorders, stress related illnesses, suicidality and self harm, lowered self esteem, depression, anxiety and other forms of psychological distress, difficulties in sexual and interpersonal relationships, unsafe sex behaviours and both delayed seeking of preventive and prenatal health care and increased rates of emergency and primary health care utilisation (Schei & Bakketeig, 1989; Koss & Heslet, 1992; Koss 1994; Springs & Friedrich, 1992; Irwin, Edlin & Wong, 1995; Walker et al., 1995; Acierno et al.,1996; Resnick, Acierno & Kilpatrick, 1997; Dietz et al., 1997).

Violence results in multiple short and long term physical and psychological effects. Delineating the important causative and mediating factors involved in this complex web of interrelatedness and how they determine specific negative outcomes is the critical task now confronting researchers and clinicians (Resnick, Acierno, Kilpatrick, 1997). As the health effects of violence are multiple and overlapping the interrelationships between them are unlikely to be simple.

Barriers to understanding

The task of understanding these interrelationships founders on a number of hurdles. First and most basic, there is poor ascertainment of violence in health care settings despite repeated calls for routine screening of all women (American Medical Association on Scientific Affairs, 1992). Low rates of detection compound the health problems associated with violence. As Acierno, Resnick and Kilpatrick's (1997) observe:

> ***The complexity of violence-related negative health outcomes increases when victimisation remains undetected. Victims of violence are more likely to present repeatedly to healthcare providers, yet in nonidentified cases, treatments are necessarily directed at symptoms rather than etiologic factors. (p62)***

Another impediment to understanding is that the extent of comorbidity among all negative health effects has not been adequately ascertained. Establishing the level of psychological and biophysiological comobidity between the multiple adverse health outcomes of violence is a necessary prerequisite to understanding the cumulative burden they place on women's health. This burden will be a function of all violence related outcomes and their interrelationships, even those that may make a relatively small contribution to overall variance in health outcomes. If multiple adverse health outcomes of violence are present the resulting burden may be summative, multiplicative or derive from complex reciprocal relationships between variables.

Evidence that the burden is likely to derive from complex reciprocal relationships, comes from the longitudinal research of Kilpatrick et al., (1997) on the directionality of the relationship between violence and substance use. This revealed a series of relationships between assault and substance use including a vicious cycle whereby substance use increased risk of future assault and assault increased risk of subsequent substance use.

A dynamic relationship between the occurrence and recurrence of violence and changes in the level of substance abuse is suggested by this research. Not only did drug use increase the risk of victimisation but in previously non-victimised women, drug use following the assault increased the risk a new assault occurring. Moreover, a new assault in women who had previously not used drugs initiated an increased risk of drug use. These findings support Lenore Walker's (1989) earlier view that in accounting for the psychological impact of violence: ***'It is the synthesis and synergy of the contextual variables that are seen as more important than any one variable' (p696).*** The contribution of violence to the production of a high level of psychiatric comorbidity amongst women must be elucidated, especially in the light of the strong relationship between violence and a variety of psychological disorders and the way in which these tend to cluster within certain individuals.

An analysis of data from the National Comorbidity Survey (Kessler et al ,1994), found that nearly 80% of all the lifetime disorders measured in the Survey occurred in respondents with comorbid disorders. This finding is particularly important given the fact that women had higher prevalences than men of both lifetime and 12- month comorbidity of three or more disorders and that the most common disorder was major depression, where women predominate.

Accounting for violence

To ascertain the true extent of the contribution of violence to comorbidity and overall health burden, a means of accounting for the cumulative effect of violence on health must be developed. Such a measure would adopt a lifespan perspective, acknowledge the cyclical nature of much interpersonal violence, the additional health impact of revictimisation and register the multiple forms, frequency, severity and duration of the violence experienced.

The complex relationships between violence, depression and a number of other psychological disorders poses certain challenges to standard conceptual distinctions. For example, the estimates of disease burden for 2020 noted in the Global Burden of Disease, (Murray & Lopez, 1996), include three conditions which severely threaten women's emotional well being, namely depression, violence and self inflicted injury. At the same time, these conditions are highly interconnected with one another. Indeed each may also be considered as a risk factor for one another and for other physical and psychological conditions and health behaviours as well. Retaining a clear conceptual division between risk factor and outcome is thus somewhat problematic.

Although the comorbidity of diseases is not estimated in the Global Burden of Disease, it must be addressed if the total burden imposed by violence on women's health is to be ascertained. On the other hand, the notion of comorbidity retains the idea of separate and separable effects and may not be the most useful way of thinking about the health outcomes of violence and the resultant burden on women's health. At the very least, the weighting of comorbid conditions may need to adjusted according to their number and the extent of victimisation involved. As Levins (1995) has observed in relation to emerging diseases, effective analyses demand the study of complexity and this study may constitute the 'central general scientific problem of our time.'

Coping with violence

Another consideration in attempting to elucidate violence related health effects is that certain disorders such as substance use disorders, can be understood as ways of coping with the psychological effects induced by violence, such as depression and anxiety. For example, substance use disorders may be conceptualised as second order effects or perhaps as intervening factors that do in fact mediate the anxiety, stress and depression associated with violence but in a way that ultimately compromises both physical and psychological health even further.

As Goldberg (1996) has commented:

> ***'Some diagnoses can be thought of as ways of dealing with states of anxiety or depression. These mechanisms lower the state of painful experience of symptoms, but may themselves be maladaptive. Phobic avoidance, hysterical dissociation and depersonalisation are all examples of this. Many problems with drugs and alcohol originally start as ways of dealing with anxiety or depression.' (p46)***

At the same time, anxiety and depression appear to play a mediating role in relation to physical health. Sutherland, Bybee & Sullivan (1998) in a longitudinal study charting changes in levels of physical and psychological abuse, injuries, physical health symptoms, anxiety and depression found that within each time interval, the effects of abuse on physical symptoms were mediated through anxiety and depression.

Thus the effects of trauma may function indirectly via the mechanism of psychological distress. Prolonged psychological distress can constitute the aftermath of trauma and lead to the initiation of negative healthcare behaviours, such as low levels of preventive health care behaviours and high levels of health risk behaviours ranging from the neglect of health to specific negative behaviours such as increased smoking, drinking, drug use and unsafe sex practices (Springs & Friedrich,1992; Kilpatrick et al., 1997).

Elucidating the complexity of violence related negative health outcomes is also complicated by the fact that psychological effects and symptoms may not be easy to differentiate from physical ones. Kimerling and Calhoun (1994) emphasised that many of the physical symptoms reported by women can equally be seen as symptoms of anxiety and depression. They suggest that victim's low use of mental health services despite high levels of psychological distress could be the consequence of them misidentifying this distress as physical illness. This misidentification may partly explain the 'masking' of the violence which often underlies symptom presentation. The Council on Scientific Affairs of the American Medical Association (1992) has stated that in women with a history of childhood sexual abuse, this history is 'almost always masked by other presenting problems.'

Of course, somatisation in adult life can indicate prior abuse. Walker et al., (1995) in their study of irritable bowel syndrome or inflammatory bowel disease, found that the best predictor of a prior history of severe childhood sexual abuse was the number of somatisation symptoms present in adult life.

Medical symptoms are significantly affected by abuse and violence. The symptoms and disorders most highly associated with a history of sexual and physical abuse among female patients with gastrointestinal disorders have been investigated. Leserman et al. (1998) research reveals the multiple physical and psychological manifestations such a history can produce. Compared with non abused women, those with a history of sexual and physical abuse were more likely to report somatic symptoms related to panic (palpitations, numbness and shortness of breath), depression (difficulty sleeping, loss of appetite), musculoskeletal disorders (headaches, muscle aches), genito-urinary disorders (vaginal discharge, pelvic pain, painful intercourse), skin disturbance (rash) and respiratory illness (stuffy nose).

Frank physical illness can be the long term result of past trauma and concurrent psychological distress. For instance, Koss and Heslet (1992) have argued that chronic physiological arousal, such as that which frequently follows violence and is consistent with a diagnosis of posttraumatic stress disorder (PTSD), might in turn lead to actual physical illnesses and impairments via its effect on endocrine functioning and the immune system.

Other researchers have stressed the need for research to investigate the long term effects of traumatic events and stress on the digestive system, the hormones that regulate eating behaviour, and the link between anxiety symptoms and food intake (Laws & Golding, 1996). Certainly, higher rates of traumatic events have been found to be related to a number of physical conditions such as irritable bowel syndrome, chronic pelvic pain and other pain syndromes and reproductive health problems (Resnick, Acierno & Kilpatrick, 1997) Conceptually such disorders are usually seen as somatoform disorders if they exist in the absence of abnormal physical findings. However, recent research suggests that immune and other responses to trauma could, in fact, bring about abnormal physical findings in the long term (Acierno Resnick & Kilpatrick, 1997)

A variety of mechanisms have been advanced to explain certain of these physical conditions. For example, high rates of chronic pelvic pain have been diagnosed amongst women reporting histories of prior child sexual abuse and/ or prior physical abuse. Resnick, Acierno and Kilpatrick (1997) have suggested that conditioning processes may be critical in causing initial physiological reactions to trauma to become part of a fear-memory network. By way of this conditioning process, such initial reactions as 'abdominal distress or pain, may become learned conditioned responses to environmental fear triggers, leading to longer term health problems'(p70). In fact, subjects abused as children have been found to have significantly lower pain thresholds in response to finger pressure, higher levels of disability associated with chronic pain and greater numbers of psychiatric disorders than other chronic pain sufferers. Pecukonis (1996) has argued that one continuing effect of the physical vulnerability experienced by abused children is to 'increase or intensify the salience of body stimuli' and that this might 'help to explain why many victims of child sexual abuse have an increased sensitivity to pelvic pain.'

A somewhat different explanation, relying on dissociation from the original abuse rather than an increased response to it, has been advanced by Walker et al., (1995). In this explanation, the pain in chronic pelvic pain is seen as a 'partial or dissociated "memory" of the abuse' whose adaptive function is to protect the sufferer from experiencing more complete memories of the emotional, physical and sexual maltreatment which occurred.

Multiple psychiatric diagnoses have commonly been found amongst survivors of child sexual abuse. While there is a particularly high prevalence of depression and anxiety, and intrusive memories of childhood abuse have been found to be predictive of the severity of depression (Brewin et al., 1996) numerous other concurrent psychological disorders have been reported. For example, Pribor & Dinwiddie (1992) in a study of the long term psychiatric consequences of incest found that on average the participants met criteria for seven psychiatric disorders on a lifetime basis.

Additional diagnoses to depression and anxiety amongst survivors of CSA include borderline personality disorder, somatisation disorder, posttraumatic stress disorder and in the case of very severe abuse, multiple personality disorder (Beitchman et al., 1992; Pribor & Dinwiddie, 1992; Kirby, Chu & Dill, 1993; Waller, 1994; Rowan et al., 1994). Increased rates of substance abuse and dependence, psychosexual dysfunction, simple and social phobia, panic disorder, suicidality, self harm and eating disorders have also been documented (Ogata et al., 1990; Root, 1991; Springs & Friedrich, 1992; Kilpatrick et al., 1997; Campbell & Lewandowski, 1997). Similarly, women who have experienced violence in adult life receive significantly more diagnoses of depression and anxiety, PTSD, dysthymia, phobias, and substance use disorders (Roberts et al., 1998).

Summary

Regardless of whether violence occurs during childhood or in adult life or is primarily physical, sexual or psychological, there is now incontrovertible evidence that women who have experienced violent victimisation, manifest greatly increased rates of depression, anxiety, PTSD and other psychological disorders in adult life compared with their non victimized counterparts (Stein et al., 1988; Winfield et al., 1990; Beitchman, et al., 1992; Mullen et al, 1993; Rowan et al., 1994).

Moreover, it has been asserted that:

> ***'most interpersonal violence is cyclical in nature and that problems resulting from interpersonal violence do not go away without appropriate trauma focused treatment.' (Acierno, Resnick, Kilpatrick, 1997, p61).***

Reducing the psychological impact of violence

Identifying and modifying factors that will improve the psychological well being of women who have experienced violence must be a high priority of any program of mental health promotion. One obvious area in which positive change can take place, is in an improved response by the health care system to women who have been victimised (Acierno, Resnick and Kilpatrick, 1997). Several factors argue powerfully for the need for careful screening of all women presenting to health care facilities. These include the cyclical nature of violence, the high level of revictimisation involved and the persistence of problems reflected in increased rates of health care utilisation by those who have been victimised.

The need for screening has been advocated repeatedly (American Medical Association on Scientific Affairs, 1992). Unfortunately, the available evidence suggests that clinical practice has not responded with much enthusiasm to the research indicating the need for changes to clinical practice nor to the guidelines provided by professional organizations. Both rates of disclosure regarding violence by patients and detection by health professionals remain low (Koss & Heslet, 1992; Sugg & Inui, 1992; Yeo & Yeo, 1993). Conversely, it has long been documented in US studies that health care utilisation rates increase significantly following violent victimisation. A possible mechanism for this findings may be that the shame, lack of disclosure and social isolation engendered by intimate violence undermines the very possibility of enlisting social support. Kouzis and Eaton (1998) in a study of medical utilization found that utilization increased fourfold when high distress was accompanied by low social support by a confidante.

In one of the earliest studies, Stark, Flitcraft and Frazier (1979) found that nearly one battered woman in five had presented at least 11 times with trauma and another 23% had presented with between 6-10 abuse related injuries to clinicians. For the vast majority of cases, the victimisation history underlying these injuries was never identified.

Koss (1994) reported that increases in health care utilisation persisted for all three years of the study period and that for each increment in the severity of criminal victimisation there were increases of 33% in physician visits and 56% in outpatient expenses. Multiply victimised women were almost twice as likely to visit their physicians as non victimised women in a year (6.9 visits compared with 3.5). Moreover, the severity of the violence and abuse is correlated with the number of somatic symptoms and the degree of functional disability women experience and significantly predicts health care visits (Leserman et al., 1998). Even when protocols for violence are established for improving detection and treatment, this may not translate into changes in clinical practice. For example, reporting on the situation in an emergency department where there are typically high rates of presentation by women experiencing domestic violence, Warshaw (1989) found that in 92% of domestic violence cases, physicians failed to give any referral or provide any follow up.

A more recent study (Sugg & Inui, 1992) found that 71% of physicians reported they did not have sufficient time to screen for violence. This implies that the modification of models of competent clinical practice to include an adequate history of victimisation has not taken place for the majority of physicians. The perception of time pressure may mask or magnify other fears held by the physicians and Sugg & Inui propose that :

> ***Problems that could be offensive or have no easy answers may not be delved into because of time pressure. (Sugg & Inui, 1992, p3160)***

Violence related health outcomes and other conditions and illnesses that do not comfortably fit into the time allocated in a standard consultation are likely to be displaced from clinical attention. This perpetuates a short sighted clinical approach where only symptoms are treated and will directly contribute to an increase in the complexity of violence related negative health outcomes (Acierno, Resnick & Kilpatrick, 1997).

Limiting treatment to the treatment of symptoms is simply ineffective for victims of violence, especially when the assaults may recur. According to the Council on Scientific

Affairs, American Medical Association (1992) the outcome of such an approach ill serves both the patient and the health care system.

> ***Treating only the symptoms initiates a cycle of patient contact with medical and mental health service providers, with the attendant risks of increasingly severe and debilitating sequelae for the patient, as well as exhaustion of resources within the system providing care. (p3188)***

The importance of those in primary care settings being able to identify women who have experienced victimisation is underscored by the finding that victims of violence have high levels of general medical care usage following victimisation but very low levels of usage of specialty mental health or victim assistance services (Koss, Woodruff & Koss, 1991).

Koss and Heslet (1992) commenting on the fact that women rarely disclose violence to physicians who do not ask about it, claim that this lack of questioning is not neutral in its effects. Rather, avoidance of the issue 'communicates a lack of permission to discuss these issues in a medical setting.'(p57) Silence by the physician can be a powerfully eloquent, though destructive form of communication about the violence in women's lives.

One Australian survey of general practice attenders, which found a prevalence rate for child sexual abuse with physical contact to be 28% (Mazza, Dennerstein & Ryan, 1996) underlines how critical questioning by practitioners can be for eliciting a history of victimisation. Of all the women who had experienced child sexual abuse, only 27% had mentioned this to their general practitioner. The commonest reason why the abuse had not been disclosed was quite simply that the doctor had not directly enquired about such experiences.

It is essential, therefore, that health care providers do not confine their interpretation of the health of adult women to current symptoms, informed only by a cross sectional view of health. Rather, there is an urgent need for them to adopt a longitudinal perspective which takes into account the cyclical but persistent nature of much interpersonal violence and understands the enduring relationship between violence and its possibly shifting physical and psychological sequelae and clinical presentations (Mammen & Astbury, 1997).

If health care professionals routinely screen for victimisation and develop treatment plans that address the cause of the trauma as well as its manifestations, more efficacious health care can be provided.

> ***'Often, knowledge of a history of victimisation provides a starting point from which to disentangle a confusion of presenting complaints and symptoms (American Medical Association on Scientific Affairs, 1992, p 3188)***

Two changes are necessary. First, improved detection of the depression and anxiety occurring within the context of a history of violent victimisation must occur. Second, health professionals need to be trained to develop a better understanding of the likely presenting somatic symptoms and disorders that have been linked to violence.

Detection of victimisation is a necessary first step, but to offer treatment entails affordable access to sufficient numbers of adequately trained health professionals who can provide appropriate trauma focussed care. If the mental health of women who have experienced violence is to be increased rather than decreased by their contacts with their health care system, such care must be widely available.

Research on depression in primary care settings conducted in a number of different countries indicates that the majority of patients who are depressed, do not present with psychological symptoms but rather with somatic complaints. Moreover, their physicians tend to be unskilled in detecting depression (Boardman et al., 1992; Ustin & Sartorius, 1995). This difficulty in detecting depression would appear to be compounded when there is a parallel need to identify violence and victimisation. As noted earlier, detection rates of women experiencing violence, not just in primary care settings but all other medical settings as well, remain low.

When psychiatric morbidity is detected during general practice consultations, patient satisfaction is increased. Patients whose psychiatric illness has been detected have reported deriving more benefit from their consultations than those in whom psychiatric illness was present but 'missed' by their doctor (May, 1992). Moreover as Koss & Heslet (1992) note:

> ***'The … act of disclosing is associated with positive changes in indicators of immune response. …The single most helpful response that can be made to a confidant about victimisation is validation of the individual's experiences' (p57)***

Psychosocial factors

Most of the research on the mental health effects of violence has been preoccupied with enumerating and understanding increased rates of psychological disorder. Factors involved in resilience and recovery have received less attention so far.

What existing research does show very clearly is that the most obvious way of reducing violence related psychological harm is to stop the violence and ensure that revictimisation does not occur. This is evident in the longitudinal study carried out by Campbell et al (1993). Women who had been but were no longer battered had significantly decreased rates of depression over time whereas there were no significant changes to the depression of those who continued to experience violence. Obviously, stopping violence and abuse is paramount. Yet to be able to leave a violent situation, a woman must have somewhere else safe to go.

Need for multilevel analysis

Multiple levels of determination contribute to the existence, perpetuation and effects of violence. Macro level or social contextual variables interact with the characteristics of individuals and groups and these interrelationships demand multilevel analyses (Diez-Roux, 1998). In other words, broad situational and environmental factors are important as well as individual factors.

A number of studies have found that the risk of partner violence is increased when the partner is unemployed and family income is at or below the poverty line (Hotaling & Sugarman, 1986; Straus & Gelles, 1986; Gelles & Cornell, 1990; Reiss and Roth, 1993). Thus women living in poverty and minority women are at heightened risk for victimisation by violence and experience higher rates of frequent, uncontrollable and threatening life events, including homelessness, than the general population (Belle, 1990; Browne, 1993).

O'Campo et al., (1995) also demonstrated that neighbourhood level variables related to the risk of partner perpetrated violence and modified individual level variables concerning the risk of violence, thus confirming once again the importance of maintaining social capital. It is now evident that the social gradient for depression is heavily gendered but that this relationship is in turn mediated by the occurrence of violence. A large, prospective longitudinal study found that women experience an increased risk of victimization when their income is below the poverty level and when they are newly divorced. Furthermore, victimization appears to increase women's risk for unemployment, reduced income and divorce (Byrne et al, 1999). In other words, violence can further weaken women's social position by operating on structural determinants of health such as employment and by implication, income at the same time as increasing their psychological vulnerability to depression and other disorders.

Depression itself has not only been found to increase the risk of an onset of physical disability but to result in a very marked increase in social disability which rose over time even when the effect of physical disability was statistically controlled (Ormel et al, 1999).

To tackle the problem of violence against women, a public health and human rights perspective is needed to reduce fundamental social inequalities affecting women. All societies have a responsibility to remove social, legal, medical, educational and financial impediments to women's safety.

Social justice demands the elimination of the gender based inequalities that perpetuate the enormous physical, psychological and social burden caused by violence and that diminish the lives of millions of the world's women.

At a broad social level there is a continuing need, more marked in some countries than in others, to improve the health, education and financial autonomy of women so they are less vulnerable to being economically dependent on violent men as their only means of survival.

Culture specific strategies are necessary if effective, sustainable changes are to take place and women's status as full human beings is to be recognised (Fischbach & Herbert, 1997).

To leave violent partners women need to have confidence that adequate legal and protective safeguards will prevent pursuit, harassment and further violence. Specific needs include access to sanctuary, safe affordable housing, adequate income, gender sensitive policing and strong community and legal sanctions against all forms of gender based violence. These needs, if met, will reduce women's vulnerability to violence and

reduce the social isolation bound up with the exercise of coercive control so characteristic of violent intimate relationships.

The violation of trust inherent in violence, especially violence from an intimate, poses a significant risk to a victimised woman's capacity to judge accurately those with whom it is safe to form close and secure attachments in the future. Certainly, the feelings of lowered self esteem, self blame, heightened vulnerability and mistrust of others that follow violence (American Medical Association Council on Scientific Affairs, 1992) suggest that disruption to confidence in forming and maintaining safe, intimate attachments is likely. Romans et al., (1995) reported that more than a third of the women who had been sexually abused as children reported fear of men and lack of trust in interpersonal relationships, especially with men, as well as sexual dysfunction.

Women who have experienced interpersonal relationships marked by severe and chronic violence experience similar mental health effects to victims of torture. These include high rates of depression and anxiety, symptoms of post traumatic stress and subsequent difficulty in establishing and maintaining relationships (Herman 1992). As Lavik et al (1996) found in their research, torture is an extremely negative and destructive interpersonal experience and a significant predictor for subsequent emotional withdrawal.

Evidence on the psychological effects of interpersonal violence raises the strong possibility that violence within an important, intimate relationship in adulthood, as well as a history of violence in childhood, is capable of destroying a secure attachment style and initiating or reinforcing an insecure attachment style.

John Bowlby's research on attachment in children concluded that attachment behaviours were 'tolerably accurate reflections of the experiences those individuals have actually had' (Bowlby, 1973, p235). The same appears to be true of adult relationships. The experience of violence might be seen as presenting an unwelcome opportunity, if not a traumatic need, to revise inner mental models of self and self in relationship. Some of the psychological disorders documented in relation to violence might well be seen to reflect the effects of such a revision.

On a psychological level, repair to the harm caused by violence is essential. All health services accessed by women, must be designed to respond to the psychological needs of women affected by violence and be informed by an understanding of the relationships obtaining between violent victimisation, gender, social position and negative health outcomes, including negative health behaviours.

Clinically, the emotional effects of minimisation, avoidance and dissociation so often associated with violence have to be addressed in ways that ameliorate the damage done to self opinion, self confidence and self efficacy. Very little controlled treatment research has been conducted with women victims of intimate partner or other forms of violence such as rape (Calhoun & Resick, 1993).

An exception is the evaluation of the effectiveness of Cognitive Processing Therapy (CPT) which was developed to treat the symptoms of PTSD in rape victims. Two groups of women, one receiving CPT and the other a wait listed control group were compared. Following twelve weekly sessions, women who had received CPT demonstrated highly

significant decreases in PTSD symptoms and improvements on measures of depression while no significant changes were found between the pre test and post test for the control group (Resick & Schnicke, 1992).

In another study (Resick & Schnicke, 1993) of the women who had met full criteria for PTSD at pre treatment , 88% no longer met these criteria after CPT treatment. At follow up 6 months after treatment, 92% no longer met PTSD criteria. In additon, while 60% of the same women met DSM 111R criteria for depression at pre treatment, this declined to 14% at posttreatment and to 11% 6 months later.

However, evidence from research on violence and some from more general research on depression and self esteem points to the protective and mediating factors associated with positive mental health outcomes and identifies which psychological outcomes may be modified. Low self esteem, for example, is known to play an important role in the development of depression and appears to be amenable to positive change in certain circumstances. Andrews and Brown (1995) in a 7 year study, found that women who originally had a negative evaluation of self were most likely to change to a positive evaluation if two life changes occurred. One involved positive changes in the quality of close relationships and the other concerned improvement in work status.

Similar findings have been reported in relation to the psychological effects of violence. In fact certain of the same factors which social research has shown are protective against depression have been replicated in studies on violence. In one study of physical violence during the childbearing year, having a confidant and social support from friends were significantly protective against violence (Gielen et al ., 1994). This replicates the large body of research on the importance of social support and the protective effect of having a confidant in relation to depression (Brown & Harris, 1978; Brown, Andrews & Harris, 1986; Brown, 1998)

In a study on sexual assault, social reactions and physical health, Ullman & Siegel (1995) found better health was reported by women who received emotional support and validation. On the other hand, worse health was related to negative social reactions to the victims thus underlining the critical role of social attitudes in mediating poor health outcomes.

Another study investigating the factors that mediated between child sexual abuse and adult psychological outcome identified several factors that were important at different time periods and these tended to be interrelated (Romans et al., 1995). Once again, confiding affectionate relationships both in adolescence and adulthood were found to be highly protective and paid employment was additionally important in adulthood. In adolescence, what the researchers describe as the ‘three strands of high school attainment – academic, sporting and social – were each important in providing girls with experiences of success and effectiveness. Having these experiences related positively to higher self esteem and better psychological outcomes in adulthood. An adequate income was also important in facilitating good outcomes.’

These few studies indicate that psychological problems in the long term are by no means inevitable and that support and intervention is possible in a variety of settings. Strategies need to be developed by health care providers, educators and others concerned with reducing the incidence and impact of violence on women, to reduce social isolation,

enhance women's social support networks and increase access, in all spheres of life, to opportunities for experiencing competence, autonomy and success. More research is also needed on the qualities of courage, resilience and capacity for recovery from violence that so many women show.

The interlocking causes of violence against women are embedded in every level of society- the individual, the family, the community and the sociocultural setting. For this reason, isolated approaches to the reduction of violence cannot be effective.

As Gomel (1997) suggests and the findings of the research reviewed here strenuously confirm, any comprehensive plan to improve women's mental health demands action on many levels. Such a plan will involve action to improve policies and legislation, to deliver direct interventions to ensure adequate, afforable and accessible community services, to guarantee that women have safe workplaces and to provide timely, accurate and accessible health information and media based strategies consonant with these objectives. Gender equity demands that women have access to education, employment and training in order to improve the structural determinants which define their lives and health. In addition, action will be taken to increase the sensitivity and relevance of services to meet women's needs - not just health care services but all those which impinge on women's lives including those delivered by the criminal justice system, education, social services and housing sector. Effective mental health promotion will be most effective when there is a qualitative improvement in the social environment to which all these factors contribute. Programs need to be developed which recognize and respond to the fact that health risks and adverse health outcomes occur in clusters not in isolation.

Only multi level, multi sectoral action is capable of facilitating such a change. To invert Walker's (1989) point, there is a pressing need to create a positive synthesis and synergy between the contextual variables that determine women's mental health in place of the current negative one. To this end, a gendered view of social capital is critical. Entrenched gender based inequality represents one form of attack on women's right to achieve good mental health, gender based violence is another. Both contribute to a tragic waste of human potential and illustrate the contention of the 1998 World Health Report's (WHO, 1998) that:

> ***Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination.***

Every effort must be made to improve this status, to remedy the human rights abuse deriving from gender based violence and to increase women's control over the determinants of their mental health.

BIBLIOGRAPHY

Abas, M. A., & Broadhead, J. C. (1997). Depression and anxiety among women in an urban setting in Zimbabwe. *Psychological Medicine, 27,* 59-71.

Abdullah, R., Raj-Hashim, R., & Schmitt, G. (1995). *Battered Women in Malaysia* . Jalan Sultan: Women's Aid Organisation.

Acierno, R. A., Kilpatrick, D. G., Resnick, H. S., Saunders, B. E., & Best, C. L. (1996). Violent assault, posttraumatic stress disorder, and depression. Risk factors for cigarette use among adult women. *Behaviour Modification, 20,* 363-384.

Acierno, R., Resnick, H. S., & Kilpatrick, D. G. (1997). Health impact of interpersonal violence. 1: Prevalence rates, case identification, and risk factors for sexual assault , physical assault, and domestic violence in men and women. *Behavioural Medicine, 23,* 53-64.

Akerlind, I., Alexanderson, K., Hensing, G., Leijon, M., & Bjurulf, P. (1996). Sex differences in sickness absence in relation to parental status. *Scandinavian Journal of Social Medicine, 24,* 27-35.

Allan, S., & Gilbert, P. (1995). A social comparison scale: psychometric properties and relationship to psychopathology. *Personality and Individual Differences, 19,* 293-299.

Allan, S., & Gilbert, P. (1997). Psychopathology and submissive behaviour. *British Journal of Clinical Psychology, 36,* 467-488.

American College of Obstetricians and Gynaecologists. (1989). *The battered woman* (ACOG Bulletin No 124). Washington, DC.

American Medical Association Council on Ethical and Judicial Affairs. (1991). Sexual misconduct in the practice of medicine. *Journal of the American Medical Association, 266,* 2741-2745.

American Medical Association on Scientific Affairs. (1992). Violence against women: relevance for medical practitioners. *Journal of the American Medical Association,* 267, 3184-3189.

Anderson, J., Martin, J., Mullen, P., Romans, S., & Herbison, P. (1993). Prevalence of childhood sexual abuse experiences in a community sample of women. *Journal of the American Academy of Child and Adolescent Psychiatry, 32,* 911-919.

Anderson, G., Yasenik, L., & Ross, C. A. (1993). Dissociative experiences and disorders among women who identify themselves as sexual abuse survivors. *Child Abuse and Neglect, 17,* 677-686.

Andrews, B., & Brown, G. W. (1988). Marital violence in the community. A

biographical approach. *British Journal of Psychiatry, 153*, 305-312.

Andrews, B., & Brown, G. W. (1995). Stability and change in low self esteem: the role of psychological factors. *Psychological Medicine, 25*, 23-31.

Angermeyer, M. C., & Klusnman, D. (1987). *From social class to social stress: new developments in psychiatric epidemiology*. New York: Springer.

Antrobus, P. (1993). *The impact of structural adjustment policies on women's health.* Paper presented at the First Regional Congress of the Medical Women's International Association, Near East and Africa Region, Nairobi, Kenya.

Arber, S., Gilbert, G. N., & Dale, A. (1985). Paid employment and women's health: A benefit or a source of strain? *Sociology of Health and Illness, 7*, 375-400.

Arber, S. (1991). Class, paid employment and family roles: making sense of structural disadvantage, gender and health status. *Social Science and Medicine, 32*, 425-436.

Arber, S. (1996). Integrating nonemployment into research into health inequalities. *International Journal of Health Services, 26*, 445-481.

Arber, S. (1997). Comparing inequalities in women's and men's health: Britain in the 1990's. *Social Science and Medicine, 44*, 773-787.

Astbury, J., Brown, S., Lumley, J., & Small, R. (1994). Birth events, experiences and social differences in post natal depression. *Australian Journal of Public Health, 18*, 176-184.

Astbury, J. (1996). *Crazy for you: The making of women's madness*. Melbourne: Oxford University Press.

Astbury, J., & Allanson, S. (1998). *Violence, attachment style and the decision to terminate a pregnancy.* Paper presented at the Biennial Meeting of the Marce Society, Iowa City, USA. June 24-28.

Astin, M. C., Lawrence, K. J., & Fox, D. W. (1993). Postraumatic stress disorder among battered women: Risk and resiliency factors. *Violence and Victims, 8*, 17-28.

Australia, Human Rights and Equal Opportunity Commission. (1993). *Human Rights and Mental Illness: report of the National Inquiry into the Human Rights of People with Mental Illness.* Canberra, Australian Government Publishing Service.

Australia, The Health Targets Implementation Committee. (1988). *Health for all Australians: report to the Australian Health Ministers' Advisory Council and the Australian Health Ministers' Conference*. Australian Government Publishing Service, Canberra.

Australian Bureau of Statistics.(1996). *Women's Safety, Australia 1996.* Australian Government Publishing Service, Canberra.

Avotri, J.Y., & Walters, V. (1999) 'You just look at our work and see if you have any freedom on earth': Ghanaian women's accounts of their work and their health. *Social Science and Medicine*, 48, 1123-1133.

Bandarage, A. (1997). *Women, population and global crisis.* London: Zed Books.

Barlow, D. H. (Ed.). (1993). *Clinical Handbook of Psychological Disorders* (2nd Edition ed.). New York & London: The Guilford Press.

Bartley, M., & Owen, C. (1996). Relation between socioeconomic status, employment and health during economic change. *British Medical Journal, 313*, 445-449.

Bassuk, E. L., Rubin, L., & Lauriat, A. (1986). Characteristics of sheltered homeless families. *American Journal of Public Health, 76*, 1097-1101.

Baumeister, A. F. (1990). Suicide as escape from the self. *Psychological Bulletin, 97*, 90-113.

Bayoudh, F., Barrak, S., BenFredj, N., Allani, R., & Hamdi, M. (1995). Study of a custom in Somalia: the circumcision of girls. *Medicine Tropicale Marseilles , 55*, 238-42.

Beck, S. R., Freitag, S. K., & Singer, N. (1996). Ocular injuries in battered women. *Ophthalmology, 103*, 148-151.

Beekman, A. T. F., Kriegsman, D. M. W., & Deeg, D. J. H. (1995). The association of physical health and depressive symptoms in the older population: age and sex differences. *Social Psychiatry and Psychiatric Epidemiology, 30*, 32-38.

Beiser, M., Cargo, M., & Woodbury, M. A. (1994). A comparison of psychiatric disorder in different cultures: depressive typologies in Southeast Asian refugees and resident Canadians. *International Journal of Methods in Psychiatric Research, 4*, 157-172.

Beitchman, J. H., Zucker, K. J., Hood, J. E., DaCosta, G. A., Akman, D., & Cassavia, E. (1992). A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect, 16*, 101-118.

Belle, D. (1982). *Lives in stress: women and depression*. Beverley Hills, CA: Sage.

Belle, D. (1988). *Women's mental health research agenda: poverty. In: Women's mental health. Occasional paper series*. Rockville MD: National Institute of Mental Health.

Belle, D. (1990). Poverty and women's mental health. *American Psychologist, 45*, 385-389.

Berkman, L., & Syme, S. (1979). Social networks, host resistance, and mortality: a nine year follow up study of Alameda County residents. *American Journal of Epidemiology, 109*, 186-204.

Berkman, L. F., & Macintyre, S. (1997). The measurement of social class in health studies: old measures and new formulations. *IARC Sci Publ, 138*, 51-64.

Bifulco, A., Brown, G. W., & Harris, T. O. (1987). Childhood loss of parent, lack of adequate parental care and adult depression: a replication. *Journal of Affective Disorders, 12*, 115-128.

Bifulco, A., Brown, G. W., & Adler, Z. (1991). Early sexual abuse and clinical depression in adult life. *British Journal of Psychiatry, 159*, 115-122.

Bifulco, A., Brown, G. W., & Harris, T. O. (1994). Childhood Experience of Care and Abuse (CECA): a retrospective interview measure. *Child Psychology and Psychiatry, 35*, 1419-1435.

Bittman, M. (1992). *Juggling time: How Australian families use time.* Canberra: Australian Government Publishing Service.

Blaxter, M. (1981). *The Health of the Children*. London: SSRC/DHSS Heinemann Educational Books.

Blaxter, M. (1990). *Health and lifestyle*. London: Routledge.

Blehar, M. C., & Oren, D. A. (1995). Women's increased vulnerability to mood disorders: integrating psychobiology and epidemiology. *Depression, 3*, 3-12.

Blue, I., Ducci, M. E., Jaswal, A., Ludermir, B., & Harpham, T. (1995). The mental health of low income urban women: case studies from Bombay, India; Olinda, Brazil; and Santiago, Chile. In T. Harpham & I. Blue (Eds.), *Urbanization and Mental Health in Developing Countries*. Aldershot: Avebury.

Boardman, A. P., Bilankis, N., Bouras, N., & Zouni, M. (1992). The detection of psychiatric cases by Greek physicians: report on a study carried out in a Greek primary care setting. *International Journal of Social Psychiatry, 38*, 235-241.

Bowlby, J. (1969). *Attachment and Loss: Volume 1. Attachment*. New York: Basic Books.

Bowlby, J. (1973). *Attachment and loss: Volume 2. Separation, anxiety and anger*. New York: Basic Books.

Bowlby, J. (1980). *Attachment and loss. Volume 3. Loss*. New York: Basic Books.

Boyce, P. M., & Todd, A. L. (1992). Increased risk of postnatal depression after emergency caesarean. *The Medical Journal of Australia, 157*, 172-174.

Breslau, N., Kessler, R. C., Chilcoat, H. D., Schultz, L. R., Davis, G. C., & Andreski, P. (1998). Trauma and posttraumatic stress disorder in the community: the 1996 Detroit Area Survey of Trauma. *Archives of General Psychiatry, 55*, 626-32.

Breslau, N., Chilcoat,H.D., Kessler, R.C., Peterson, E.L., Lucia, V.C. (1999) Vulnerability to assaultive violence: further specification of the sex difference in post-traumatic stress disorder. *Psychological Medicine, 29,*813-821.

Brewin, C. R., Hunter, E., Carroll, F., & Tata, P. (1996). Intrusive memories in depression: an index of schema activation? *Psychological Medicine, 26,* 1271-6.

Broadhead, J. C., & Abas, M. A. (1998). Life events, difficulties and depression among women in an urban setting in Zimbabwe. *Psychological Medicine, 28,* 29- 38.

Brown, G., & Harris, T. (1978). *Social Origins of Depression: A Study of psychiatric disorder in women*. London: Tavistock Publications.

Brown, G., & Prudo, R. (1981). Psychological disorder in a rural and an urban population: 1 Aetiology of depression. *Psychosocial Medicine, 16,* 813-831.

Brown G., Andrews B., & Harris T. (1986). Social support, self esteem and depression. *Psychological Medicine, 16,* 813-831.

Brown, G. W., & Harris, T. O. (Eds.). (1989). *Life Events and Illness*. New York: Guilford Press.

Brown, G., Bifulco, A., & Andrews, B. (1990). Self esteem and depression: 3 Aetiological issues. *Social psychiatry & psychiatric epidemiology, 25*, 235-243.

Brown, G. R., & Anderson, B. (1991). Psychiatric morbidity in adult in-patients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry, 148,* 55-61.

Brown, S., Lumley, J., Small, R., & Astbury, J. (1994). *Missing Voices: The experience of motherhood*. Melbourne: Oxford University Press.

Brown, G., & Moran, P. (1994). Clinical and psychosocial origins of chronic depressive episodes: 1 A community survey. *British Journal of Psychology, 165,* 447-456.

Brown, G. W., Harris, T. O., & Hepworth, C. (1995). Loss and depression: a patient and non-patient comparison. *Psychological Medicine, 25*, 7-21.

Brown, G. W., Harris, T. O., & Eales, M. J. (1996). Social factors and comorbidity of depressive and anxiety disorders. *British Journal of Psychiatry, 168*(Supplement 30), 50-57.

Brown, G. W., & Moran, P. (1997). Single mothers, poverty and depression. *Psychological Medicine, 27,* 21-33.

Brown, G. W. (1998). Genetic and population perspectives on life events and depression. *Social Psychiatry and Psychiatric Epidemiology, 33*, 363-372.

Browne, A., & Finklehor, D. (1986). Impact of child sexual abuse: A review of the

research. *Psychological Bulletin, 99*(66-77).

Browne, A. (1993). Family violence and homelessness: The relevance of trauma histories in the lives of women. *The American Journal of Orthopsychiatry, 63*(370-384).

Buist, A., & Barnett, B. (1995). Childhood sexual abuse: a risk factor for postpartum depression? *Australian and New Zealand Journal of Psychiatry, 29*, 604-608.

Buist, A. (1998) Childhood abuse, parenting and postpartum depression. *Australian and New Zealand Journal of Psychiatry, 32,* 479-487.

Burdekin, B., Carter, J., & Dethlefs, W. (1989). *Our homeless children. Report of the national inquiry into homeless children* . Canberra: Human Rights and Equal Opportunity Commission,.

Burke, T. (1998). Housing & poverty. In R. Fincher & J. Nieuwenhuysen (Eds.), *Australian Poverty* (pp. 165-184).

Calhoun, K. S., & Resick, P. A. (1993). Post Traumatic Stress Disorder. In D. H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders*. New York, London: Guilford Press. (pp. 48-98).

Campbell, J. C., & Sullivan, C. M. (1994). Relationship status of battered women over time. *Journal of Family Violence, 9*, 99-111.

Campbell, J., Kub, J. E., & Rose, L. (1996). Depression in battered women. *Journal of American Women's Association, 51*, 106-10.

Campbell, J. C., & Lewandowski, L. A. (1997). Mental and physical health effects of intimate partner violence on women and children. *The Psychiatric Clinics of North America, 20*, 353-374.

Campbell, J. C. (1998). Editorial: Abuse during pregnancy: Progress, policy and potential. *American Journal of Public Health, 88(2),* 185-7.

Chapko, M.K., Somse, P, Kimball, A.M., Hawkins R.V., Massanga, M (1999) Predictors of rape in the Central African Republic. *Health Care for Women International,* 20, 71-79.

Chappell, D., & Di Martino, V. (1998). *Violence at Work*. Geneva: International Labour Office.

Chavkin, W., & Kandall, R. (1990). Between a rock and a hard place: Perinatal drug abuse. *Pediatrics, 85*, 223-225.

Cheasty, M., Clare, A. W., & Collins, C. (1998). Relation between sexual abuse in childhood and adult depression: case-control study. *British Medical Journal, 316*, 198-201.

Cooper, P. J., & Murray, L. (1995). Course and recurrence of postnatal depression. Evidence for the specificity of the diagnostic concept. *British Journal of Psychiatry, 166,* 191-195.

Cox, E. S. *Violence against women in Central America and its impact on reproductive health.* Paper presented at the Safe Motherhood Central America Conference, Guatemala. (1992, 27-31 January, 1992).

Coyle, B. S., Wolan, D. L., & VanHorn, A. S. (1996). The prevalence of physical and sexual abuse in women veterans seeking care at a Veterans Affairs Medical Centre. *Military Medicine, 161,* 588-593.

Coyne, J.C. (1994). Self reported distress: Analog or ersatz depression? *Psychological Bulletin, 116,* 29-45.

Craig, T. K. J. (1996). Adversity and depression. *International Review of Psychiatry, 8,* 341-353.

Croghan, T. W., Obenchain, R. L., & Crown, W. E. (1998). What does treatment of depression really cost? *Data Watch, 17,* 198-208.

Crow, T. J. (1986). Secular changes in affective disorder and variations in the psychosis gene. *Archives of General Psychiatry, 43,* 1013-1014.

Dahl, S., Mutapcic, A., & Schei, B. (1998). Traumatic events and predictive factors for posttraumatic symptoms in displaced Bosnian women in a war zone. *Journal of Traumatic Stress, 11,* 137-145.

Davies, M. (1994). *Women and Violence: Realities and responses worldwide*. London: Zed Books.

Dennerstein, L., Astbury, J., & Morse, C. (1993). *Psychosocial and mental health aspects of women's health.* Geneva: World Health Organization.

Denton M., & Walters, V. (1999) Gender differences in structural and behavioral determinants of health: an analysis of the social production of health. *Social Science & Medicine, 48,* 1221-1235.

Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1995). *World Mental Health, Problems and Priorities in Low Income Countries*. New York: Oxford University Press.

Dietz, P. M., Gazmararian, J. A., Goodwin, M. M., Bruce, F. C., Johnson, C. H., & Rochat, R. W. (1997). Delayed entry into prenatal care: effect of physical violence. *Obstetric Gynecology, 90,* 221-4.

DiezRoux, A. V. (1998). Bringing context back into epidemiology: Variables and fallacies in multi-level analysis. *American Journal of Public Health, 88,* 216-222.

Dijkstra, A. G., & Hanmer, L. C. (1997). *Measuring socioeconomic gender*

inequality: Towards an alternative to the UNDP Gender-Related Development Index (Working paper). The Hague: Institute of Social Studies.

Di Matteo, M. R., Morton, M. R., Lepper, H. S., Damush, T. M., Carney, M. F., Pearson, M., & Kahn, K. L. (1996). Cesarean childbirth and psychosocial outcomes: a meta-analysis. *Health Psychology, 15*, 303-314.

Dixon, A. K., Fisch, H. U., Huber, C., & Walser, A. (1989). Ethological studies in animals and man: their use in psychiatry. *Pharmacopsychiatry, 22*, 44-50.

Dohrenwend, B. P., Levav, I., Shrout, P. E., Link, B. G., Skodol, A. E., & Martin, J. L. (1987). Life stress and psychopathology: progress on research begun with Barbara Dohrenwend. *American Journal of Community Psychology, 15*(6), 677-715.

Dohrenwend, B. P. (1990). Socioeconomic status (SES) and psychiatric disorders. *Social Psychiatry and Psychiatric Epidemiology, 25*, 41-47.

Eaton, W. W., & Kessler, L. G. (1985). *Epidemiologic field methods in psychiatry: the NIMH Epidemiologic Catchment Area Program*. Orlando: Academic Press.

Edwards, D. R., Porter, S. A., & Stein, G. S. (1994). A pilot study of postnatal depression following caesarean section using two retrospective self-rating instruments. *Journal of Psychosomatic Research, 38*, 111-7.

Eichler, A., & Parron, D. L. (1987). *Women's mental health: Agenda for research*. Rockville MD: National Institute of Mental Health.

Elliot, D. M. (1997). Traumatic events: Prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology, 65*, 811-820.

Elliott, B. J., & Huppert, F. A. (1991). In sickness and in health: associations between physical and mental well-being, employment and parental status in a British nationwide
sample of married women. *Psychological Medicine, 21*(2), 515-524.

Ellsberg, M. C. (1997). *Candies in hell: Domestic violence against women in Nicaragua.* Unpublished Licentiate, Umea University.

Evans, R. G. (1994). Introduction. In R. G. Evans, M. L. Barer, & T. R. Marmor (Eds.), *Why are some people healthy and others not? The determinants of health of populations*. New York: Aldine De Gruyter. (pp. 3-26).

Evins, G., & Chescheir, N. (1996). Prevalence of domestic violence among women seeking abortion services. *Women's Health Issues, 6*, 204-10.

Farmer, P. (1997). Social scientists and the new tuberculosis. *Social Science and Medicine,* 44, 353

Fauveau, V., & Blanchet, T. (1989). Deaths from injuries and induced abortion among rural Bangladesh women. *Social Science and Medicine, 29*, 1121-1127.

Feinstein, J. S. (1993). The relationship between socioeconomic status and health: a review of the literature. *Millbank Quarterly, 71*, 279-322.

Feldman-Summers, S., & Jones, G. (1984). Psychological impact of sexual contact between therapists or other heath care practitioners and their clients. *Journal of Consulting and Clinical Psychology, 52*, 1054-1061.

Ferguson, K. S., & Dacey, C. M. (1997). Anxiety, depression, and dissociation in women health care providers reporting a history of childhood psychological abuse. *Child Abuse and Neglect, 21*, 941-52.

Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualisation. *American Journal of Orthopsychiatry, 55*, 530-541.

Finkelhor, D., Hoatling, D., Lewis, G., & Smith, I. A. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics and risk factors. *Child Abuse and Neglect, 14*, 19-28.

Finlay-Jones, R. (1989). Anxiety. In G. W. Brown & J. D. Harris (Eds.), *Life Events and Illness* . New York: Guilford Press.

Fishbach, R. L., & Herbert, B. (1997). Domestic violence and mental health: correlates and conundrums within and across cultures. *Social Science and Medicine, 45*, 1161-76.

Fisher, B., Hovell, M., Hofstetter, C. R., & Hough, R. (1995). Risks associated with long-term homelessness among women: battery, rape and HIV infection. *International Journal of Health Services, 25*, 351-369.

Fisher, J., Astbury, J., & Smith, A. (1997). Adverse psychological impact of operative obstetric interventions: a prospective longitudinal study. *Australian and New Zealand Journal of Psychiatry, 31*, 728-738.

Fleming, R., & Easting, K. (1994). *Couples, Households and Money: The report of the Pakeha component of the Intra family study* . Wellington, New Zealand: Wellington and Palmerston North, Intra- Family Income Project in association with the Social Policy Centre, Massey University.

Fleming, J. M. (1997). Prevalence of childhood sexual abuse in a community sample of Australian women. *Medical Journal of Australia, 166*, 65-68.

Friedman, L. S., Samet, J. H., Roberts, M. S., Hudlin, M., & Hans, P. (1992). Inquiry about victimization experiences: A survey of patient preferences and physician practices. *Archives of Internal Medicine, 152*, 1186-1190.

Frieze, I. H., & Browne, A. (Eds.). (1989). *Violence in marriage*. Chicago: University of Chicago Press.

Gabbard, G. O., & Nadelson, C. (1995). Professional boundaries in the physician

patient relationship. *Journal of the American Medical Association, 273*, 1445-1449.

Gaminde, I., Uria, M., Padro, D., Querejeta, I., & Ozamiz, A. (1993). Depression in three populations in the Basque country- a comparison with Britain. *Social Psychiatry and Psychiatric Epidemiology, 28*, 243-251.

Gazmararian, J. A., Lazorick, S., Spitz, A. M., Ballard, T. J., Saltzman, L. E., & Marks, J. S. (1996). Prevalence of violence against pregnant women. *Journal of the American Medicial Association, 275*, 1915-1920.

Geist, R. F. (1988). Sexually related trauma. *Emergency Medical Clinics of North America, 6*, 439-66.

Gelles, R., & Cornell, C. (1990). *Intimate Violence in Families*. (2nd edition ed.). Newbury Park: Sage.

George, D.M., Carroll, P., Kersnick, R., Calderon, K. (1998) Gender-related patterns of helping among friends. *Psychology of Women Quarterly, 22*,685-704.

Gielen, A. C., O'Campo, P., Faden, R., Kass, N., & Xue, N. (1994). Interpersonal conflict and physical violence during the childbearing year. *Social Science and Medicine, 39*, 781-787.

Gilbert, P. (1992). *Depression: The evolution of powerlessness*. Hove: Lawrence Erlbaum Associates.

Gilbert, L., el-Bassel, N., & Friedman, E. (1997). Childhood abuse as a risk for partner abuse among women in methadone maintenance. *American Journal of Drug and Alcohol Abuse, 23*, 581-95.

Gilbert, P., & Allan, S. (1998). The role of defeat and entrapment (arrested flight) in depression: an exploration of an evolutionary view. *Psychological Medicine, 28*, 585-598.

Gitlin, M. J., & Pasnau, R. O. (1989). Psychiatric syndromes linked to reproductive function: A review of current knowledge. *American Journal of Psychiatry, 146*, 1413-1422.

Glander, S. S., Moore, M. L., Michielutte, R., & Parsons, L. H. (1998). The prevalence of domestic violence among women seeking abortion. *Obstetrics and Gynecology, 91*, 1002-1006.

Gleason, W. J. (1993). Mental disorders in battered women: An empirical study. *Violence and Victims, 8*, 53-68.

Goldberg, D., Bridges, R., Cook, D., Evans, B., & Grayson, D. (1990). The influence of social factors on common mental disorders: destabilisation and restitution. *British Journal of Psychiatry, 156*, 704-713.

Goldberg, D. (1996). A dimensional model for common mental disorders. *British*

Journal of Psychiatry, 168 (Supplement 30), 44-49.

Golding, J. M., Cooper, M. L., & George, L. K. (1997). Sexual assault history and health perceptions: seven general population studies. *Health Psychology, 16,* 417-25.

Gomel, M. K. (1997). *A Focus on Women*. Geneva: World Health Organization.

Goodman, L. A., Koss, M. P., & Russo, N. F. (1993). Violence against women. Part 1: Research findings. *Applied and Preventive Psychology, 2,* 79-89.

Goshko, J. (1999,). Push to protect children in war. *The Age*, pp. 9.

Green, J. M., Coupland, V. A., & Kitzinger, J. (1990). Expectations, experiences and psychological outcomes of childbirth: a prospective study of 825 women. *Birth, 17,* 15-24.

Green, G., Macintyre, S., West, P., & Ecob, R. (1991). Like parent like child? Associations between drinking and smoking behaviour of parents and their children. *British Journal of Addiction, 86,* 745-758.

Halbreich, U., & Lumley, L. A. (1993). The multiple interactional biological processes that might lead to depression and gender differences in its appearance. *Journal of Affective Disorders, 29,* 159-173.

Hall, L., Williams, C., & Greenberg, R. (1985). Supports, stressors and depressive symptoms in low income mothers of young children. *American Journal of Public Health, 75,* 518-522.

Handwerker, W. (1993). Gender power differences between parents and high-risk sexual behaviour by their children. *Journal of Women's Health,* 2, 310-316.

Hannah, P., Adams, D., Lee, A., Glover, V., & Sandler, M. (1992). Links between early post-partum mood and post natal depression. *British Journal of Psychiatry, 160,* 777-780.

Hartigan, P. (1999). Communicable diseases, gender and equity in health. Working Paper Series, Number 99.08. Harvard Centre for Population and Development Studies. Harvard School of Public Health. Cambridge, MA.

Hartzell, K. N., Botek, A. A., & Goldberg, S. H. (1996). Orbital fractures in women due to sexual assualt and domestic violence. *Ophthalmology, 103,* 953-957.

Harvey, S., Jarrell, J., Brant, R., Stainton, C., & Rach, D. (1996). A randomized controlled trial of nurse-midwifery care. *Birth, 23,* 128-135.

Hatch, M., & Moline, J. (1997). Women, work and health. *American Journal of Industrial Medicine, 32,* 303-308.

Hazan, C., & Shaver, P. (1987). Romantic love conceptualised as an attachment process. *Journal of Personality and Social Psychology, 52,* 511-524.

Hegarty, K., & Roberts, G. (1998). How common is domestic violence against women? The definition of partner abuse in prevalence studies. *Australian and New Zealand Journal of Public Health, 22,* 49-54.

Heise, L. L., Pitanguy, J., & Germain, A. (1994). Violence against women. The hidden health burden. *Social Science and Medicine, 39,* 233-245.

Heise, L. L., Raikes, A., Watts, C. H., & Zwi, A. B. (1994). Violence against women: A neglected public health issue in less developed countries. *Social Science and Medicine, 39,* 1165-1179.

Heise, L. L., (1996). Health workers: Potential allies in the battle against woman abuse in developing countries. *Journal of the American Woman's Association, 51* 120-2.

Helgeson, V.S., & Fritz, H.L. (1999) A theory of unmitigated communion. *Personality and Social Psychology Review, 2,* 173-183.

Helton, A. S., McFarlane, J., & Anderson, F. T. (1987). Battered and pregnant: a prevalence study. *American Journal of Public Health, 77,* 1337-1339.

Helzer, J. E. (1986). The increased risk for specific psychiatric disorders among persons of low socioeconomic status: evidence from the epidemiologic catchment area surveys. *American Journal of Social Psychiatry, 4,* 59-71.

Helzer, R. E., Robins, L. N., & McEnvoy, L. (1987). Post-traumatic stress disorder in the general population. Findings of the epidemiologic catchment area survey. *New England Journal of Medicine, 317*(1630-4).

Henderson, A.S., Jorm, A.F., Korten, A.E., Jacomb, P., Christensen, H., Rodgers, B. (1998) Symptoms of depression and anxiety during adult life: Evidence for a decline in prevalence with age. *Psychological Medicine, 28,* 1321-1328.

Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence: From domestic abuse to political terror*. New York: Basic Books.

Hewitt, J. B., & Levin, P. F. (1997). Violence in the workplace. *Annual Review of Nursing Research, 15,* 81-99.

Hotaling, G. T., & Sugarman, D. B. (1986). An analysis of risk makers in husband to wife violence: the current state of knowledge. *Violence Victims, 1,* 101-124.

Hochschild, A. (1989). *The Second Shift*. New York: Viking.

Holmes, M. M., Resnick, H. S., Kilpatrick, D. G., & Best, C. L. (1996). Rape-related pregancy: Estimates and descriptive characteristics from a national sample of women. *American Journal of Obstetrics and Gynecology, 175,* 320-325.

Irwin, K. L., Edlin, B. R., & Wong, L. (1995). Urban rape survivors: Characteristics

and prevalence of human immunodeficiency virus and other sexually transmitted infections. *Obstetrics and Gynecology, 85,* 330-336.

Jack, D. C. (1991). *Silencing the Self: Women and Depression*. Cambridge, Mass: Harvard University Press.

Jordan, J., Kaylan, A., & Surrey, J. L. (1991). *Women's growth in connection: Writings from the Stone Centre*. New York: Guilford Publications.

Jordan, M. (1998) Report in International Herald Tribune, September 7, p.8.

Kaplan, G. A., Roberts, R. E., Camacho, T. C., & Coyne, J. C. (1987). Psychological predictors of depression. Prospective evidence from the human population laboratory studies. *American Journal of Epidemiology, 125*(2), 206-220.

Kaplan, G. A., Pamuk, E. R., Lynch, J. W., Cohen, R. D., & Balfour, J. L. (1996). Inequality in income and mortality in the United States: analysis of mortality and potential pathways. *British Medical Journal, 312,* 999-1003.

Karasek, R. A. (1979). Job demands, job decision latitude and mental strain: implications for job redesign. *Administrative Science Quarterly, 24,* 285-308.

Kawachi, I., Kennedy B.P., Lochner, K., Prothrow-Stith, D.(1997) Social capital, income inequality, and mortality. *American Journal of Public Health, 87,* 1491-1498.

Kawachi, I., Kennedy, B.P., Glass, R. (1999) Social capital and self-rated health: A contextual analysis. *American Journal of Public Health, 89,* 1187-1193.

Kennedy, B.P., Kawachi, I., Glass, R., Prothrow-Stith. (1998) Income distribution, socioeconomic status, and self-rated health in the United States: multilevel analysis. *British Medical Journal, 317,* 917-921.

Kellerman, A., & Mercy, J. A. (1995). Men, women and murder: Gender specific differences in rates of fatal violence and victimization. *Journal of Trauma, 33 (1),* 1-5.

Kendler, S. K., Kessler, R. C., Neale, M. C., Heath, A. C., & Eaves, L. J. (1992). The prediction of major depression in women: Towards an integrated etiologic model. *American Jounal of Psychiatry, 150,* 1139-1148.

Kessler, R. C., Forster, C., Webster, P. S., & House, J. S. (1992). The relationship between age and depressive symptoms in 2 national surveys. *The Psychology of Ageing, 7,* 119-126.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S., Wittchen, H. U., & Kendler, K. S. (1994). Lifetime and 12 month prevalence of DSM-111-R psychiatric disorders in the United States. *Archives of General Psychiatry, 51,* 8-19.

Kessler, R. C., Sonnega, A., Bromet, E., Hughes, M., & Nelson, C. (1995).

Posttraumatic stress disorder in the National Comorbidity Survey. *Archives of General Psychiatry, 52*, 1048-1060.

Kilpatrick, D. G., Veronen, L. J., & Best, V. L. (1985). Factors predicting pscychological stress among rape victims. In C. R. Fingley (Ed.), *Trauma and Its Wake* . New York: Brunner/ Mazel.

Kilpatrick, D. G., Edmonds, C. N., & Seymor, A. K. (1992). *Rape in America: A report to the nation* . Arlington, VA: National Victim Center.

Kilpatrick, D. G., Acierno, R., Resnick, H. S., Saunders, B. E., & Best, C. L. (1997). A 2 year longitudinal analysis of the relationships between violent assault and substance use in women. *Journal of Consulting and Clinical Psychology, 65(5),* 834-47.

Kilpatrick, D. G., Resnick, H. S., & Acierno, R. (1997). Health impact of interpersonal violence. 3: Implications for clinical practice and public policy. *Behavioural Medicine, 23*, 79-85.

Kimerling, R., & Calhoun, K. S. (1994). Somatic symptoms, social support, and treatment seeking among sexual assault victims. *Journal of Consulting and Clinical Psychology, 62*, 333-340.

Kirby, J. S., Chu, J. A., & Dill, D. L. (1993). Correlates of dissociative symptom aetiology in patients with physical and sexual abuse histories. *Comprehensive Psychiatry, 34*, 867-874.

Kirmani, M. N., & Munyakho, D. (1996). The impact of structural adjustment programs on women and AIDS. In L. D. Long & E. M. Ankrah (Eds.), *Women's experience with HIV/AIDS: An International Perspective* (pp. 160-178). New York: Columbia University Press.

Kitney, G. (1999, 6-2-99). Global backlash. *The Age*, pp. 19.

Klein, M. C., Gauthier, R. J., Jorgensen, S. H., Robbins, J. M., Kaczorowski, J., Johnson, B., Corriveau, M., Westreich, R., Waghorn, K., Gelfand, M. M. (1992). Does episiotomy prevent perineal trauma and pelvic floor relaxation. *Oline Journal of Current Clinical Trials, Jul 1*, Doc no 10.

Kleinschmidt, K. C. (1997). Elder abuse: A review. *Annals of Emergency Medicine, 30*, 463-472.

Kluft, R. P. (1989). Treating the patient who has been sexually exploited by a previous therapist. *Psychiatric Clinics of North America, 12*, 483-500.

Kolko, G. (1999) Ravaging the poor: the International Monetary Fund indicted by its own data. *International Journal of Health Services,29*, 51-57.

Kornblit, A. L. (1994). Domestic violence-An emerging health issue. *Social Science and Medicine, 39*, 1181-1188.

Koss, M. P., Koss, P. G., & Woodruff, J. (1991). Deleterious effects of criminal victimization on women's health and medical utilization. *Archives of Internal Medicine, 151*, 342-347.

Koss, M., & Heslet, L. (1992). Somatic consequences of violence against women. *Archives of Family Medicine, 1*, 53-59.

Koss, M. P. (1994). The Negative Impact of Crime Victimization on Women's Health and Medical Use. In A. Dan (Ed.), *Reframing Women's Health* (pp. 189-199). Thousand Oaks, California: Sage.

Kouzis, A.C., & Eaton, W.W. (1998) Absence of social networks, social support and health services utilization. *Psychological Medicine, 28,* 1301-1310.

Kubany, E. S., McKenzie, W. F. M., Owens, J. A., Leisen, M. B., Kaplan, A. S., & Pavich, E. (1996). PSTD among women survivors of domestic violence in Hawaii. *Hawaii Medical Journal,* (55), 164-5.

Kunst, A. E., Geurts, J. M., & Berg, v. d. (1995). International variation in socioeconomic inequalities in self reported health. *Journal of Epidemiology and Community Health, 49,* 117-123.

Lahelma, E., Manderbacka, K., Rahkonen, O., & Karisto, A. (1994). Comparisons in health: evidence form national surveys in Finland, Norway, and Sweden. *Social Science and Medicine, 44*, 789-799.

Lavik, N. J., Hauff, E., Skrondal, A., & Solberg, D. (1996). Mental disorder among refugees and the impact of persecution and exile: Some findings from an out-patient population. *British Journal of Psychiatry, 169*, 726-732.

Laws, A., & Golding, J. M. (1996). Sexual assault history and eating disorder symptoms among white, Hispanic and African-American women and men. *American Journal of Public Health, 86*, 579-82.

Lawson, J. S., & Black, D. (1993). Socioeconomic status: the prime indicator of premature death in Australia. *Journal of Biosocial Sciences, 25*(539-552).

Leathers, S.J., Kelley,M.A., Richman, J.A. (1997) Postpartum depressive symptomatology in new mothers and fathers: parenting, work and support. *Journal of Nervous and Mental Diseases, 185, 129-139.*

Lee, S. H. (1988). *Women's Health Data Requirements* . Canberra: Australian Government Publishing Service.

Leggett, A. (1995). Origins and development of the injunction prohibiting sexual relationships with patients. *Australian and New Zealand Journal of Psychiatry, 29*, 586-590.

Lemieux, A. M., & Coe, C. L. (1995). Abuse-related posttraumatic stress disorder:

evidence for chronic neuroendocrine activation in women. *Psychosomatic Medicine, 57*, 105-115.

LeQuesne, C. (1996). From GATT to WTO: The results of the Uruguay Round. In B. Coote (Ed.), *The trade trap: poverty and the global commodity markets* (pp. 192-215). Oxford: Oxfam.

Leserman, J., Li, Z., Drossman, D. A., & Hu, Y. J. (1998). Selected symptoms associated with sexual and physical abuse history among female patients with gastrointestinal disorders: the impact on subsequent health care visits. *Psychological Medicine, 28*, 417-425.

Leslie, J., Lycette, M., & Buvinic, M. (1988). The crucial role of women in health. In D. Bell & M. Reich (Eds.), *Health, Nutrition and the Economic Crises: Approaches to Policy in the Third World* (pp. 307-348). Dover, MA: Auburn House.

Letourneau, E. J., Resnick, H. S., Kilpatrick, D. G., Saunders, B. E., & Best, C. L. (1996). Comorbidity of sexual problems and posttraumatic stress disorder in female crime victims. *Behaviour Therapy, 27*, 321-336.

Leventhal, J. M. (1990). Epidemiology of child sexual abuse. In R. K. Oates (Ed.), *Understanding and managing child sexual abuse* . Sydney: Harcourt Brace Jovanovich.

Levins, R. (1996). Preparing for uncertainty. *Ecosystem Health,* 1, 47-54.

Levinson, D. (1989). *Family violence in cross cultural perspective.* Newbury Park: Sage.

Littlewood, R. (1997). Military rape. *Anthropology Today, 13*, 7- 15.

Loewenson, R.H. (1999) Women's occupational health in globalization and development.*American Journal of Industrial Medicine, 36*, 34-42.

Long, L.D., Ankrah, E.M. (Eds.). (1996). *Women's experience with HIV/AIDS.* New York: Columbia University Press.

Macintyre, S. (1986). The patterning of health by social position in contemporary Britain: directions for sociological research. *Social Science and Medicine, 23*, 393-415.

Macintyre, S., Hunt, K., & Sweeting, H. (1996). Gender differences in health: are things really as simple as they seem? *Social Science and Medicine, 42*, 617-624.

Macintyre, S. (1997). The Black Report and beyond: what are the issues? *Social Science and Medicine, 44*, 723-745.

Macran, S. (1993). *Role enhancement or role overload? A review of research on the health consequences of women's domestic and paid work* (Research paper 93-1). London: London School of Hygiene and Tropical Medicine.

Macran, S., Clarke, L., Sloggett, A., & Bethune, A. (1994). Women's socioeconomic status and self-assessed health: identifying some disadvantaged groups. *Social Health and Illness, 16*, 182.

Macran, S., Clarke, L., & Joshi, H. (1996). Women's health: dimensions and differentials. *Social Science and Medicine, 42*(9), 1203-1216.

Makovsky, V. (1982). Sources of stress: Events or conditions? In D. Belle (Ed.), *Lives in stress* (pp. 35-53). Beverly Hills, California: Sage Publications.
Mamers, P.M., Lavelle, A., Evans, A.J., Bell, S.M., Rusden, J.R & Healy, D.L. (1997) Women's satisfaction with medical abortion with RU486. *Medical Journal of Australia*, 167, 316-317.

Mammen, G., & Astbury, J. (1997). Taking the consequences of childhood sexual abuse. *Medical Journal of Australia, 167*, 238-239.

Marcus, R. (1993). *Violence against women in Bangladesh, Pakistan, Egypt, Sudan, Senegal and Yemen* (10): Report prepared for the Special Programme WID Netherlands Ministry of Foriegn Affairs(DGIS).

Margolin, L. (1992). Sexual abuse by grandparents. *Child Abuse and Neglect, 16*, 735-742.

Mari, J. J., Almeida-Filho, N., Coutinho, E., Baxter, A. S., Miranda, C. T. d., & Streiner, D. (1993). The epidemiology of psychotropic use in the city of Sao Paulo. *British Journal of Psychiatry, 148*, 23-26.

Martin, J., Anderson, J., Romans, S., Mullen, P., & O'Shea, M. (1993). Asking about child sexual abuse: Methodological implications of a two-stage survey. *Child Abuse and Neglect, 17*, 383-392.

Mastroianni, A. C., Faden, R., & Federman, S. (1994). *Women and health research: Ethical and legal issues of including women in clinical studies.* Washington DC: Institute of Medicine, National Academy Press.

May, S. (1992). Patient satisfaction and the detection of psychiatric morbidity in general practice. *Family Practice, 9*, 76-81.

Mazza, D., Dennerstein, L., & Ryan, V. (1996). Physical, sexual and emotional violence against women: a general practice based prevalence study. *Medical Journal of Australia, 164*, 14-17.

McBride, B. A. (1990). Mental health effects of women's multiple roles. *American Psychologist, 45*, 381-384.

McCauley, J., Kern, D. E., Kolodner, K., Dill, L., Schroeder, A. F., DeChant, H. K., Ryden, J., Bass, E. B., & Derogatis, L. R. (1995). The 'Battering Syndrome': Prevalence and clinical characteristics of domestic violence in Primary Care Internal Medicine Practices. *Annals of Internal Medicine, 123*, 737-746.

McFarlane, J., Parker, B., Soeken, K., & Bullock, L. (1992). Assessing for abuse during pregnancy. *Journal of the American Medical Association, 267*, 3176-3178.

McFarlane, A. C., & Papay, P. (1992). Multiple diagnoses in posttraumatic stress disorder in the victims of a natural diaster. *Journal of Nervous Mental Disorders, 180*, 498-504.

Milo, N. (1981). *Promoting Health Through Public Policy*. Philadelphia: F A Davis.

Mirowsky, J., & Ross, C. E. (1992). Age and depression. *Journal of Health and Social Behaviour, 33*, 187-205.

Moncrieff, J., Drummond, D. C., Candy, B., Checinski, K., & Farmer, R. (1996). Sexual abuse in people with alcohol problems. A study of the prevalence of sexual abuse and its relationship to drinking behaviour. *British Journal of Psychiatry, 169*, 355-360.

Morris, E. M., Martin, J. L., & Romans, S. E. (1998). Professional help sought for emotional problems: coping with child sexual abuse in a Dunnedin community sample of women. *New Zealand Medical Journal, 111*, 123-6.

Moser, C. (1991). *Conference Proceedings.* Paper presented at the 18th Annual NIH International Health Conference, Arlington, VA.

Mullen, P. E., Romans-Clarkson, S. E., Walton, V. A., & Herbison, P. (1988). Impact of sexual and physical abuse on women's mental health. *Lancet, 16*, 841-845.

Mullen, P. E., Martin, J. L., Anderson, J. C., Romans, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry, 163*, 721-732.

Murray, J. L., & Lopez, A. D. (1996). *The global burden of disease: A comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020. Summary*. Boston: Harvard School of Public Health, World Health Organization.

Musselman, D. L., Evans, D. L., & Nemeroff, C. B. (1998). The relationship of depression to cardiovascular disease. *Archives of General Psychiatry, 55*, 580-592.

Najman, J. M. (1993). Health and poverty: past, present and prospects for the future. *Social Science and Medicine, 36*(2), 157-166.

Narasimyhan, S. (1994). India: From Sati to Sex Determination Tests. In M. Davies (Ed.), *Women and violence* . London: Zed Books.

Nash, M. R., Hulsey, T. L., Sexton, M. C., Harralson, T. L., & Lambert, W. (1993). Long term sequelae of childhood sexual abuse: Perceived family environment, psychopathology and dissociation. *Journal of Consulting and Clinical Psychology, 61*, 276-283.

Neugebauer, D. D., Dohrenwend, B. P., & Dohrenwend, B. S. (1980). The formulation of hypotheses about the true prevalence of functional disorder among adults in the United States. In B. P. Dohrenwend, B. S. Dohrenwend, M. S. Gould, B. Link, R. Neugebauer, & R. Wunsch-Hitzig (Eds.), *Mental Illness in the United States* (pp. 45-94). New York: Praeger.

Newton-Taylor, B., DeWit, D., & Gliksman, L. (1998). Prevalence and factors associated with physical and sexual assault of female university students in Ontario. *Health Care for Women International, 19,* 155-164.

Nolen-Hoeksema, S. (1987). Sex differences in unipolar depression: evidence and theory. *Psychological Bulletin, 101,* 259-282.

Norton, L. B., Piepert, J. F., Zierler, S., Lima, B., & Hume, L. (1995). Battering in pregnancy: an assessment of two screening methods. *Obstetric Gynaecology, 85,* 321-325.

O'Campo, R., Gielen, A. C., Faden, R. R., Xue, X., Kass, N., & Wang, M. C. (1995). Violence by male partners during the childbearing year: a contextual analysis. *American Journal of Public Health, 85,* 1092-1097.

Ogata, S., Silk, K. R., Goodrich, S., Lohr, N. E., Western, D., & Hill, E. M. (1990). Childhood sexual and physical abuse in adult patients with borderline personality disorder. *American Journal of Psychiatry, 147,* 1008-1013.

Okojie, C. E. E. (1994). Gender inequalities of health in the third world. *Social Science and Medicine, 39,* 1237-1247.

Olavarrieta, C. D., & Sotelo, J. (1996). Domestic violence in Mexico. *Journal of the American Medical Association, 275,* 1937-1941.

Ormel, J., Oldehinkel, A. J., Goldberg, D., Hodiament, P. P. G., Wilmink, F. W., & Bridges, K. (1995). The structure of common psychiatric symptoms: how many dimensions of neurosis? *Psychological Medicine, 25,* 521-530.

Ormel, J., Vonkorff, A.J., Oldehinkel, G.S., Tiemens, B.G., Ustun,T.B. (1999) Onset of disability in depressed and non depressed primary care patients. *Psychological Medicine, 29,* 847-853.

Pan American Health Organization. (1995). *The health situation of women in Latin America* . Washington, DC.

Parker, B., McFarlane, J., & Soeken, K. (1994). Abuse during pregnancy: effects on maternal complications and birth weight in adult and teenage women. *Obstetric Gynaecology, 84,* 323-8.

Patel, V., Araya, R., de Lima, M., Ludermir, A., Todd, C. (1999) Women, poverty and common mental disorders in four restructuring societies. *Social Science & Medicine,49,* 1461-1471.

Patel,V., Todd, C., Winston, M., Gwanzura, F., Simunyu E., Acuda, W., Mann, A (1998) Outcome of common mental disorders in Harare, Zimbabwe. *British Journal of Psychiatry, 172,*53-57.

Paykel, E. S. (1994). Life events, social support and depression, Acta Psychiatra Scandinavia. In J. Lonnqvist & T. Sahi (Eds.), *Depression: Preventative and Risk Factors* (Vol. 89 supplement 377, pp. 50-58). Copenhagen: Munksgaard.

Pearlin, L., & Johnson. (1977). Marital status, life strains and depression. *American sociological review, 42,* 704-715.

Pecukonis, E. V. (1996). Childhood sex abuse in women with chronic intractable back pain. *Social Work and Health Care, 23,* 1-16.

Peterson, R., Gazmararian, J. A., Spitz, A. M., Rowley, D. L., Goodwin, M. M., Saltzman, L. E., & Marks, J. S. (1997). Violence and adverse pregnancy outcomes: A review of the literature and directions for future research. *American Journal of Preventive Medicine, 13*(5), 366-73.

Piccinelli, M., & Homen, F. G. (1997). *Gender differences in the epidemiology of affective disorders and schizophrenia*. Geneva: World Health Organization.

Pill, R., & Stott, N. C. H. (1982). Concepts of illness causation and responsibility: some preliminary data from a sample of working class mothers. *Social Science and Medicine,*16, 43-52.

Pill, R., Peters, T., & Robling, M. R. (1993). Factors associated with health behaviour among mothers of lower socio-economic status: A British example. *Social Science and Medicine, 36,* 1137-1144.

Popay, J., Bartley, M., & Owen, C. (1993). Gender inequalities in health: social position, affective disorders and minor physical morbidity. *Social Science and Medicine, 36*(1), 21-32.

Power, C. (1994). Health and social inequality in Europe. *British Medical Journal, 308,*
1153-1156.

Pribor, E. F., & Dinwiddie, S. H. (1992). Psychiatric correlates of incest in childhood. *American Journal of Psychiatry, 149,* 52-56.

Pritchard, C. (1990). Suicide, unemployment and gender variations in the western world 1964-1986. *Social Psychiatry and Psychiatric Epidemiology, 25,* 73-80.

Pugh, H., Power, C., Goldblatt, P., & Arber, S. (1991). Women's lung cancer mortality, socioeconomic status and changing smoking patterns. *Social Science and Medicine, 32,* 1105-1110.

Raeburn, J. M., & Rootman, I. (1989). Towards an expanded health field concept:

conceptual and research issues in a new era of health promotion. *Health Promotion, 3*, 383-392.

Rahkonen, O., Lahelma, E., Karisto, A., & Manderbacka, K. (1993). Persisting health inequalities: social class differentials in illness in the Scandinavian countries. *Journal of Public Health Policy, 14*, 66-81.

Raskin, S. A. (1997). The relationship between sexual abuse and mild traumatic brain injury. *Brain Injuries, 8*, 587-603.

Ratner, P. (1993). The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta. *Canadian Journal of Public Health, 84*, 246-249.

Reiss, A. J., & Roth, J. A. (1993). *Understanding and Preventing Violence*. Washington DC: National Academy Press.

Resick, P. A., Jordan, C. G., Girrelli, S. A., Hutter, C. K., & Marhoefer-Dvorak, S. (1989). A comparative outcome study of behavioural group therapy for sexual assault victims. *Behavioural Therapy, 19*, 385-401.

Resick, P. A., & Schnicke, M. K. (1992). Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology, 60*, 748-756.

Resnick, H. S., Kilpatrick, D. G., Seals, B., Acierno, R., & Nayak, M. (1996). *Rape and HIV risk: Implications for prevention.* Paper presented at the Presented at the annual meeting of the Society for Traumatic Stress Studies, San Francisco, CA.

Resnick, H. S., Acierno, R., & Kilpatrick, D. G. (1997). Health impact of interpersonal violence. 2: Medical and mental health outcomes. *Behavioural Medicine, 23*, 65-78.

Resnick, M. D., Bearman, P. S., Plum, R. W., Bauman, K. E., Harris, K. M., Jones, J., Tabor, J., Beuhring, T., Sieving, R. E., Shew, M., Ireland, M., Bearinger, L. H., & Udry, J. R. (1997). Protecting adolescents form harm. Findings from the National Longitudinal Study on Adolescent Health. *Journal of the American Medical Association, 278(10)*, 823-832.

Roberts, G. L., Lawrence, J. M., Williams, G. M., & Raphael, B. (1998). The impact of domestic violence on women's mental health. *Australian and New Zealand Journal of Public Health, 22*, 796-801.

Romans, S. E., Martin, J. L., Anderson, J. C., O'Shea, M. L., & Mullen, P. E. (1995). Factors that mediate between child sexual abuse and adult psychological outcome. *Psychological Medicine, 25*, 127-142.

Root, M. P. (1991). Persistent disordered eating as a gender-specific post-traumatic stress response to sexual assault. *Psychotherapy, 28*, 96-102.

Rowan, A. B., Foy, D. W., Rodriguez, N., & Ryan, S. (1994). Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse and*

Neglect, 18, 51-61.

Rozemberg, B., & Manderson, L. (1998). 'Nerves' and tranquillizer use in rural Brazil. *International Journal of Health Services, 28*, 165-181.

Rubinow, D. R. (1992). The premenstrual syndrome: new views. *Journal of the American Medical Association, 268*, 1908-1912.

Russell, D. E. (1983). The incidence and prevalence of intrafamilal and extra familial sexual abuse of female children. *Child Abuse and Neglect, 7*, 133-146.

Russell, D. (1986). *The Secret Trauma: Incest in the lives of girls and women*. New York: Basic Books.

Russo, N. F. (1990). Overview: forging research priorities for women's mental health. *American Psychologist, 45*, 368-73.

Saltman, D. (1991). *Women and Health: An introduction*. Sydney: Harcourt Brace Jovanovich.

Saunders, D. G., & Hamberger, K. (1993). Indicators of woman abuse based on chart review at a family practice centre. *Archives of Family Medicine, 2*, 537-543.

Schei, B., & Bakketeig, L. S. (1989). Gynaecological impact of sexual and physical abuse by spouse: A study of a random sample of Norwegian women. *British Journal of Obstetrics and Gynaecology, 96*, 1379-1383.

Shadbolt, B. (1996). Health consequences of social role careers for women: a life course perspective. *Australian and New Zealand Journal of Public Health, 20*, 172-180.

Shaver, S. (1998). Poverty, gender and sole parenthood. In R. Fincher & J. Nieuwenhuysen (Eds.), *Australian poverty then and now*. Melbourne: Melbourne University Press. (pp. 259-276)

Simons, R. L., & Whitbeck, L. B. (1991). Sexual abuse as a precursor to prostitution and victimization among adolescent and adult homeless women. *Journal of Family Issues, 12*, 361-379.

Skinner, C. J., & Forster, G. (1995). The coexistence of physical and sexual assault (letter; comment). *American Journal of Obstetrics and Gynaecology, 172*, 1644-5.

Smith, M. D. (1987). The incidence and prevalence of woman abuse in Toronto. *Violence and Victims, 2*, 173-183.

Smith, G. D. (1996). Income inequality and mortality: why are they related? *British Medical Journal, 312*, 987-988.

Sorenson, S. B., & Golding, J. M. (1990). Depressive sequelae of recent criminal victimisation. *Journal of Trauma Stress, 3*(1154-1164).

Sperberg, E.D., & Stabb, S.D. (1998) Depression in women as related to anger and mutuality in relationships. *Psychology of women Quarterly, 22,* 223-238.

Springs, F. E., & Friedrich, W. N. (1992). Health risk behaviours and medical sequelae of childhood sexual abuse. *Mayo Clinic Proceedings, 67,* 527-532.

Standing, H. (1997). Gender and equity in health sector reform programmes: a review. *Health Policy and Planning, 12,* 1-18.

Stansfeld, S. A., Head, J., & Marmot, M. G. (1998). Explaining social class differentials in depression and well-being. *Social Psychiatry and Psychiatric Epidemiology, 33,* 1-9.

Stark, E., Flitcraft, A., & Frazier, W. (1979). Medicine and patriarchal violence: the social construction of a 'private' event. *International Journal of Health Services, 9,* 461-493.

Stark, E., & Flitcraft, A. (1995). Killing the beast within: woman battering and female suicidality. *International Jounal of Health Services, 25,* 43-64.

Stark, E., & Flitcraft, A. (1996). *Women at risk: Domestic violence and women's health.* Thousand Oaks: Sage.

Stein, J. A., Golding, J. M., Siegel, J. M., Burnam, M. A., & Sorenson, S. B. (1988). Long term psychological sequelae of child sexual abuse: The Los Angeles Epidemiologic Catchment Area Study. In G. E. Wyatt & G. J. Powell (Eds.), *Lasting Effects of Child*
Sexual Abuse. Newbury Park, Cal.: Sage. (pp. 135-154)

Stein, J. (1997). *Empowerment and women's health: Theory, methods and practice*. London, New Jersey: Zed Books.

Stewart, L., Sebastiani, A., Delgado, G., & Lopez, G. (1996). Consequences of sexual abuse of adolescents. *Reproductive Health Matters, 7,* 129-134.

Stewart, M. J., Brosky, G., & Gillis, A. (1996). Disadvantaged women and smoking. *Canadian Journal of Public Health, 87,* 257-260.

Straus, M. A. (1979). Measuring intrafamily conflict and violence: the Conflict Tactics (CT) Scales. *Journal of Marriage and the Family, 41,* 75-88.

Straus, M. A., & Gelles, R. J. (1986). Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. *Journal of Marriage and Family, 48,* 465-479.

Sugg, N. K., & Inui, T. (1992). Primary Care physicians' response to domestic violence. *Journal of the American Medical Association, 267,* 3157-3160.

Sutherland, C., Bybee, D., & Sullivan, C. (1998). The long-term effects of battering on women's health. *Women's Health, 4,* 41-70.

Tessler, R. L., & Dennis, D. L. (1989). *A synthesis of NIMH funded research concerning persons who are homeless and mentally ill*. Rockville, Maryland: National Institute of Mental Health.

Thomas, D. Q. (1994). In search of solutions: Women's police stations in Brazil. In M. Davies (Ed.), *Women and violence* . London: Zed Books.

Townsend, P., & Davidson, N. (1982). *Inequalities in health: the Black report.* Harmondsworth: Peguin.

Trewthewy, J. (1989). *Aussie battlers. Families and children in poverty.* Melbourne: Collins Dove.

Turner, R. J., & Marino, F. (1994). Social support and social structure: a descriptive epidemiology of a central stress mediator. *Journal of Health and Social Behaviour, 35,* 193-212.

Ullman, S. E., & Siegel, J. M. (1995). Sexual assault, social reactions, and physical health. *Women's Health, 1,* 298-308.

Umberson, D., Chen, M.U., House,J.S., Hopkins,K., & Slaten, E. (1996). The effect of social relationships on psychological well-being: Are men and women really so different? *American Sociological Review, 61,* 837-857.

United Nations Development Program. (1993). *Human Development Report*. New York, Oxford University Press.

United Nations Development Program. (1995) *Human Development Report.* New York,
Oxford University Press.

United Nations. (1995). *Beijing Platform of Action* . Geneva: UN Publications.

United Nations Development Program. (1997). *Human Development Report*. New York, Oxford University Press.

US Institute of Medicine. (1988). *Homelessness, health and human needs*.Washington,DC.

Ustin, T. B., & Sartorius, N. (1995). *Mental illness in General Health Care: An international study*: John Wiley on behalf of the World Health Organization.

Vazquez-Barquero, J. L., Diez-Manrique, J. F., Munoz, J., Menendez, J. A., Gaite, L., Herrera, S., & Der, G. J. (1992). Sex differences in mental illness: a community study of the influence of physical health and sociodemographic factors. *Social Psychiatry and Psychiatric Epidemiology, 27,* 62-68.

Verbrugge, L. M. (1983). Multiple roles and physical health of women and men.

Journal of Health and Social Behaviour, 24, 16-30.

Vlassoff, C. (1994). Gender inequalities in health in the third world: Uncharted ground. *Social Science and Medicine, 39*, 1249-1259.

Wade, T. J., & Cairney, J. (1997). Age and depression in a nationally representative sample of Canadians: A preliminary look at the National Population Health Survey. *Canadian Journal of Public Health, 88*, 297-302.

Wadsworth, M. E. (1997). Health inequalities in the life course perspective. *Social Science and Medicine, 44*, 859-869.

Walberg, P., McKee, M., Shkolnikov, V., Chenet, L., & Leon, D. A. (1998). Economic change, crime and mortality crisis in Russia: regional analysis. *British Medical Journal, 317*, 312- 318.

Waldron, I., & Jacobs, J. A. (1989). Effects of multiple roles on women's health - evidence from a national longitudinal study. *Women's Health, 15*, 3-19.

Walker, L. (1989). Psychology and violence against women. *American Psychologist, 44*, 695-702.

Walker, E. A., Gelfand, A. N., Gelfand, M. D., & Katon, W. J. (1995). Psychiatric diagnosis, sexual and physical victimization, and disability in patients with irritable bowel syndrome or inflammatory bowel disease. *Psychological Medicine, 25*, 1259-67.

Walker, L. (1996). *Abused Women and Survivor Therapy: A Practical Guide for the Psychotherapist*. Washington DC: American Psychological Association.

Waller, G. (1994). Childhood sexual abuse and borderline personality disorder and eating disorders. *Child Abuse and Neglect, 18*, 97-101.

Warshaw, C. (1989). Limitations of the medical model in the care of battered women. *Gender and Society, 3*, 506-517.

Webster, J., Sweett, S., & Stolz, T. A. (1994). Domestic violence in pregnancy. A prevalence study. *Medical Journal of Australia, 161*, 466-470.

Weine, S. M., Becker, D. F., & McGlashan, T. (1995). Psychiatric consequences of 'ethnic cleansing': clinical assessments and trauma testimonies of new resettled Bosnian refugees. *American Journal of Psychiatry, 152*, 532-542.

Weston, R. (1996). Experience of health and health related lifestyle patterns. In P. M. McDonald (Ed.), *Australian Living Standards Study: Box Hill report* (pp. 293-366). Melbourne: Australian Institute of Family Studies.

Whitehead, M., Judge, K., Hunter, D. J., Maxwell, R., & Scheuer, M. A. (1993). Tackling inequalities in health: the Australian experience. *British Medical Journal, 306*, 783-7.

Whiffen, V. E., & Clark, S. E. (1997). Does victimization account for sex differences in depressive symptoms. *British Journal of Clinical Psychology, 36*((Pt 2)), 185-93.

Wilkinson, R. G. (1997). Socioeconomic determinants of health. Health inequalities: relative or absolute material standards? *British Medical Journal, 314*, 591- 595.

Wilkinson, R.G.(1997) Comment: Income, inequality and social cohesion.*American Journal of Public Health, 87,*1504-1506.

Wilkinson, R. G. (1998). Mortality and distribution of income. *British Medical Journal, 316*, 1611-1612.

Williams, L. M. (1994). Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology, 62*, 1167-1176.

Winfield, I., George, L. K., Swartz, M., & Blazer, D. G. (1990). Sexual assault and psychiatric disorders among a community sample of women. *American Journal of Psychiatry, 147*, 335-341.

Wing, J. K., Cooper, J. E., & Satouris, N. (1974). *The measurement and classification of psychiatric symptoms.* Cambridge: Cambridge University Press.

Wood, K., Maforah, F., & Jewkes, R. (1998) 'He forced me to love him': Putting violence on adolescent sexual health agendas. *Social Science and Medicine*, 47, 233-242.

World Bank. (1994). *A new agenda for women's health and nutrition. Development in practice series*. Washington DC.

World Health Organization. (1981). *Social dimensions of mental health* (5). Geneva.

World Health Organization, Health and Welfare Canada. (1986). *Ottawa charter for health promotion* Canadian Public Health Association.

World Health Organization, Women's Health and Development. (1996). *Female Genital Mutilation* . Geneva.

World Health Organization. (1997). *Violence against women: A priority health issue*. Geneva.

World Health Organization. (1998). *The World Health Report, 1998. Executive summary*. Geneva

Wyatt, G. E., Guthrie, D., & Notgrass, C. M. (1992). Differential effects of women's child sexual abuse and subsquent sexual revictimization. *Journal of Consulting and Clinical Psychology,60*, 167-173.

Yama, M. F., Tovey, S. L., & Fogas, B. S. (1993). Childhood family environment and

sexual abuse as predictors of anxiety and depression in adult women. *American Jornal of Orthopsychiatry, 63,* 136-141.

Yeo, H. M., & Yeo, W. W. (1993). Repeat deliberate self harm: A link with childhood sexual abuse? *Archives of Emergency Medicine, 10,* 161-166.

Yoder, R. (1989). Are people willing and able to pay for health services? *Social Science and Medicine, 29 (1),* 34-42.

Ziebland, S., Thorogood, M., Yudkin, P., Jones, L., & Coulter, A. (1998). Lack of willpower or lack of wherewithal? 'Internal' and 'external' barriers to changing diet and exercise in a three year follow up of participants in a health check. *Social Science and Medicine, 46,* 461-465.

Zunzunegui, M. V., Beland, F., Llacer, A., & Leon, V. (1998). Gender differences in depressive symptoms among Spanish elderly. *Social Psychiatry and Psychiatric Epidemiology, 33,* 195-205.