

Gender Impact Assessment No. 1



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Women and Depression

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(Gender Impact Assessment No. 1)

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Introduction

Depression commonly refers to feelings of ongoing low mood, unhappiness or distress. The term 'depression' 'describes a group of illnesses which all have the characteristic of excessive and long term mood disturbance, often accompanied by feelings of anxiety'¹. The causes of depression are now understood to be complex and relate to the interaction of many diverse factors, including environmental, social, biological and psychological risk. The Global Burden of Disease Study estimated that by 2020, depression will become the second greatest cause of disease burden in the world².

The issue

At any given time an estimated 450 million people worldwide are affected by mental, neurological or behavioural problems, and over 870 000 of those die annually from suicide³. In Australia, depression is cited as one of the highest mental health risk factors for suicide and suicidal behaviour, and contributes to suicide being a leading cause of death in Australia.

The World Health Organisation's (WHO) *Gender in Mental Health Report* states that mental health disorders of childhood tend to be more prevalent in boys than girls, but that later in age, women are more likely to suffer poorer mental health, particularly depression and eating disorders, than men⁴. In Australia, one in four women and one in six men will experience depression at some stage in their life⁵. Depression is a major health problem for Australian women and is frequently accompanied by other psychological problems such as anxiety disorders and post-traumatic stress disorder⁶.

Gender difference

Early attempts to provide explanations for the prevalence of depression in women were sought from biologically based sex differences², but associations are now made with social factors and context of living.

The WHO states that biological or hormonal explanations of depression in women are overly simplistic. Instead, the WHO argues that women's depression can be linked to their exposure to social determinants of health, which differ to men's. Women exposed to stressors associated with those determinants experience a higher incidence of depression than men⁴. Stressors unique to women may include negative life events, such as violence and abuse, discrimination and the denial of or limited access to education and occupation opportunities, which lead to fewer options when confronted with economic or social difficulties⁴.

It is now also recognised that gendered divisions of labour in the economy, the home and the community, and gender based expectations about roles, responsibilities and power relations contribute to women's higher risk of depression⁷.

Socio-economic status

The Australian Bureau of Statistics (ABS) states that adults living in the most socio-economically disadvantaged areas in Australia have a higher prevalence of mental or

behavioural problems and psychological distress⁸. This includes depression. Socio-economic factors, such as lower rates of pay, part-time and casual employment and unemployment that increase vulnerability to depression⁷. The WHO agrees that depression is more common among those who are economically vulnerable or who are living in poverty, and states that this population is usually women and children⁴.

Depression, violence and abuse

Violence is linked to increased incidence of depression and women are more likely to be victims of violence than men⁴. The greatest risk of violence for women comes from their male partners, with between ten and fifty percent of women globally affected by domestic violence³. A recent Australian study found that a history of domestic violence was associated with decreased psychological well-being in mid-aged women⁹.

Sexual violence in youth is linked to adolescent depression, and sexual abuse as a child is significantly associated with depression in adult women⁴. Rape will cause one in three women to experience depression, excessively use drugs or attempt suicide¹⁰.

Postnatal depression

Postnatal depression affects ten to fifteen percent of women after childbirth and is one of the most common and least often diagnosed complications for new mothers^{5,11}. Post-natal depression is related to the physicality of childbearing. However, risk factors for a depressive disorder following childbirth are predominantly psychosocial and may include the absence of personal support, marital conflict, experiences of childhood abuse or a history of anxiety and depression⁸. Research has also shown that where cultural value is placed on boys and not girls, women who give birth to a girl may be at greater risk of post-natal depression³.

Indigenous women

Discrimination and disadvantage can cause mental distress and lead to depression. Aboriginal women have a cultural history of trauma and loss linked to the impact of colonisation and family removal. They continue to experience disadvantage, high levels of domestic violence and sexual abuse¹².

Sexuality

In a heterosexist society where discrimination exists against sexualities not conforming to opposite-sex rules of attraction and behaviour (heterosexuality), high rates of depression, anxiety, suicide attempt and suicide completion can be found in lesbian, gay, bisexual and transgender communities¹³.

Diagnosis and treatment

Findings from research into gender difference and diagnosis of depression varies. An Australian study found that women are almost twice as likely as men to be diagnosed with depression, anxiety disorders, and major and longstanding depressive disorders¹⁴. However, a later WHO sponsored study found that men and women are equally likely to be diagnosed

with depression⁴. Other research shows that doctors, family and friends may not recognise depression in women, and that women themselves may not identify it¹⁵.

In the treatment of depression, Australian women are significantly more likely to be prescribed antidepressant drugs than Australian men. The WHO also finds an association between being female and being prescribed psychotropic drugs for depression⁴. This gender difference in treatment extends to the prescription of sleeping pills and vitamins for depression, with more women than men being prescribed both⁴.

Policy contexts and challenges

Government responses

In June 1995, the Mental Health Branch of Department of Health Services (DHS) in Victoria established a Women's Advisory Group in order to provide advice on program and policy development priorities for women using mental health services. The Women's Advisory group identified a number of priorities and strategies for the improvement of these services and in 1997 published *Victoria's Mental Health: Tailoring Services to meet the needs of Women*¹⁶.

In 2002, the *New Directions for Victoria's Mental Health Services: The Next Five Years* was published by the Metropolitan Health and Aged Care Services Division of DHS. It refers to the *Women's Health and Wellbeing Strategy* for outlining key strategic directions for improving the health and wellbeing of Victorian women. The report also offers a number of programs and services specific to women with mental illness. These include

- Two specialist pilot projects that will provide practical home-based support and links with community services for women with a mental illness who have dependant children.
- Detection of antenatal and postnatal depression by primary care services, including maternal and child health services and general practitioners
- Building partnerships between mental health, sexual assault and domestic violence services.

The *Victorian Strategy for Safety and Quality in Public Mental Health Services 2004-2008* states that service responses should to be sensitive to individual needs including gender. It aims to 'promote and protect consumer and carer rights' with respect given to gender, but no gender differences are outlined and no gender specific goals are set.

The *Cultural diversity plan for Victoria's specialist mental health services 2006-2010*, released in 2005, identifies gender as a factor to be considered with cultural diversity, but is otherwise gender blind. Within its 'Mental health and ethnicity' subheading it lists refugees and asylum seekers, older Australians from non-English speaking backgrounds, young people and children, and people in rural areas as risk categories, but does not identify women as a separate risk group.

Women and children are specified in the 2005 publication, *Identifying and Responding to Family Violence: A Guide for Mental Health Clinicians in Victoria*. Herein, women and children are named as the most common 'victims' in family violence. The document provides guidelines for mental health practitioners and services for working with women and children. It also gives guidelines for working with men, whom they name as most likely to perpetrate violence. This report specifies depression as one of many 'symptoms' of family violence.

In the 2006 Background Paper to VicHealth's *Position Statement on Health Inequalities*, gender is cited as a factor that influences health, but details about how and why this is so is largely omitted.

Another 2006 publication, *An Introduction to Victoria's Public Clinical Mental Health Services*, refers to 'being mindful' about gender issues and cites gender as one among many cultural factors that 'significantly influences the way mental illness and treatment is understood, and the nature and timing of help-seeking for mental health problems'. Within 'Principles of Treatment', it states, that gender, among other factors, should be taken into consideration. In identifying the purpose of the publication, it states: 'This document is intended as an overview of the public clinical mental health sector. It provides essential policy, practice and legal information for day-to-day clinical work across the range of work settings and consumer age groups'. Despite this, no detail is given to specific consumer groups. Although gender is mentioned, the document does not explain why gender is a factor for mental health services and no details are given about the specific mental health needs for women.

In 2007, the Mental Health Branch of DHS undertook a project to 'consider gender sensitivity and safety in adult acute mental health inpatient units'. A Newsletter has been produced for March and September. The Gender Sensitivity and Safety in Adult Acute Mental Health Inpatient Units Project Advisory Committee completed a literature review and allocated Environmental Improvement Grants to mental health providers in Victoria. These grants were specifically for improved alterations in the physical environment of mental health services for female consumers. The literature review identified a requirement to optimise the safety of women in-patients in mental health services. Over September 2007, the Committee aims to study a range of acute inpatient units in Victoria to identify what is working well and what barriers may exist to achieving gender sensitivity and safe care.

At a National level, the *National Mental Health Plan 2003-2008* is guided by four priority themes including: promoting mental health and preventing mental health problems and illness; increasing service responsiveness; strengthening quality; and fostering research. However, it fails to consider any specific gender differences in mental health diagnoses, illness course, experiences, treatment, impacts and outcomes.

Non-government responses

'Social Inclusion', 'Freedom from Discrimination and Violence', and 'Access to Economic Resources' are the three components of VicHealth's 'Themes for Action' in their *Mental Health Promotion Framework 2005-2007*. The framework identifies women and men as separate population groups. Gender is listed as a determinant in the experience of discrimination and violence is specifically used in the context of violence against women. VicHealth recognises the link between mental health and exposure to violence, and have developed a public health model aimed at the prevention of violence against women. However, neither or the other two key themes, 'Social Inclusion' and 'Access to Economic Resources' identifies gender differences.

Beyondblue is a national depression organisation¹⁷ that together with partner stakeholders raises awareness about depression and anxiety, provides consumer information, develops prevention packages, and conducts training and research. Its website is a major source of information for the public and for service providers. Postnatal depression is one of the site's four main topics: 'Depression', 'Anxiety', 'Bi-polar Disorder', and 'Postnatal Depression'. *Beyondblue*'s Postnatal Depression Program has provided screening to over 40 000 women

and given resource packages about postnatal depression to more than 100 000 women. Screening for postnatal depression is one of *beyondblue*'s priority areas for the five years of 2005-2010. For wider distribution, their 'Emotional Health During Pregnancy and Early Parenthood' information booklet has been translated into 19 languages.

Outside of postnatal depression, the *beyondblue* website appears to target depression in men. Despite acknowledging that women are twice as likely to experience depression than men, the number of photographs on the website are disproportionately aimed at men, including those used for the 'Depression' links. The organisation provides a Factsheet (number 12) specifically about depression in men, but does not produce one about depression in women (other than postnatal depression). There are links to *Men's Health Week* and information about depression in men on that page also. The only real acknowledgement that women experience depression differently from men is linked back to postnatal depression and menses.

This is illustrated on the *beyondblue* 'Risk Factor' page for depression, where age, women, men, sexual orientation, Indigenous people, and living in rural and remote areas are identified as risk factors. However, within the category 'Women', reference is only made to postnatal depression, premenstrual dysphoric disorder (PMDD) and post menopause. No social indicators of depression in women are given. There is no mention about socioeconomic status, social gender inequities, about disparities in socioeconomic status, cultural gender biases or details about the impact of violence and abuse, largely perpetrated by men against women, and which would seemingly warrant a risk category of its own.

*Reconnexion*¹⁸, another Victorian based organisation that provides counselling services for people experiencing depression and anxiety disorders, also has a male photograph as its website visual and for downloadable brochures. However, the webpage for 'Depression' has a photograph of a woman on it and also identifies depression and twice as likely in women than men. It follows this statement with a list of social risk factors including employment, violence, sexual assault and financial problems that can all contribute to depression. Postnatal depression and depression in children and young people are two identified categories for counselling.

On the *Black Dog Institute*¹⁹, a NSW based organisation, there is a 'Gender' subcategory under 'Causes of Depression', but information on this page suggests that evidence to support gender difference in experience of depression is incomplete, although it states that more women experience 'non-melancholic depression' than men. In an information PDF sheet, 'Real' reasons are given to be social in as much as 'parents interact with their sons and daughters in different ways so 'girls might be at greater risk of internalising disorders', and 'women are more likely to focus on their partners and their families', while men are able to 'obtain their self-esteem and exert power across the public sphere'. In explanation for some research claims that women have a greater propensity than men to experience depression, biological reasons, specifically hormonal, are given. No reference to wider gender differences, social inequities, gender-role biases, experiences of violence and abuse etc is made.

Information contained on the *Sunrise Foundation*²⁰ website, which is aimed at educating athletes about depression appears to be gender blind. So too, the national organisation, *Sane Australia*²¹, refers to depression sometimes being associated with childbirth, but is otherwise gender blind around depression. *Depressionnet*²² is an online service that provides information and support for people experiencing depression. Eight types of depression are listed, among which Postnatal depression is one. However, the rest of the site makes no reference to gender difference and the three main causes of depression given are Unhealthy lifestyle, Grief and Loss, and Hormonal Changes. *Depression.com.au*²³, which provides information about depression and national services, has a link for postnatal depression, mentions that 20% of women and 10% of men will experience depression, but is otherwise gender blind.

Conclusion

Life context and social and structural determinants are shown to inform health experience. Research findings increasingly identify gender as a determinant of mental health and women continue to have higher incidences of depression than men. Yet, despite this, local and national policies and service provision generally fails to reflect, inform, plan or provide for this. It highlights the need for gender mainstreaming across all government and non-government departments and services. This would raise awareness about the various and multiple ways mental health, and depression, is influenced and experienced differently by women and men. It would assist the implementation of gender responsive planning, policy-making and practice.

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