Women's Mental Health

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American Psychiatric Association
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American Psychiatric Foundation
The American Psychiatric Foundation is the philanthropic and educational arm of the American Psychiatric Association. The mission of the foundation is to advance understanding that mental illnesses are real and can be effectively treated. For more information, please visit the foundation's Web site at www. psychfoundation.org.

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I Introduction

Millions of women in the United States are affected by mental disorders. While mental illnesses are treatable, many women with mental illness are undiagnosed, untreated, or undertreated. Needless suffering hurts not only the individual, but also her family and the greater society. To address these issues, the American Psychiatric Association (APA) and American Psychiatric Foundation (APF) hosted the Women's Mental Health Roundtable and Leadership Summit (the Summit) on December 11, 2007.

The goal of the Summit was to bring together leaders of national organizations concerned with the health, mental health, and well-being of women to identify key issues and to begin to create and advance an agenda to improve women's mental health through strategic and collaborative action. The organizers of the Summit saw the need to expand traditional alliances of mental health organizations to include groups representing a range of organizations with a vested interest in women's health and welfare and who would bring unique viewpoints and resources to the table. Promoting mental health in women and increasing access to treatment will require the collaboration of policy makers, advocates, and health professionals from a variety of disciplines.

The meeting was chaired by outgoing APF President Altha Stewart, MD. Participants in the Summit included representatives of health and mental health organizations, academia, nonprofit advocacy organizations, federal agencies, and others. (See the appendix for a list of participating organizations.) APA's Women's Mental Health Roundtable was sponsored by APF through an unrestricted educational grant from Wyeth Pharmaceuticals. This issue paper on women's mental health was prepared as a follow-up to the meeting. The paper is intended to provide an overview of the status of women's mental health in America and to highlight recommendations for action that were discussed at the Summit.

This report is divided into six sections. Section one is an overview of women's mental health data that emphasizes the importance of these issues. The second section looks at the status of women's mental health in relation to specific disorders, including depression, suicide, anxiety, and eating disorders. The third section discusses mental health issues among special populations of women, including ethnically and racially diverse women, incarcerated women, primary caregivers, and others. The fourth section takes a look at barriers to care for women, and the fifth highlights a few innovative trends and approaches addressing some of the issues raised. The final section is a summary and recommendations.

Compelling Reasons to Focus on Women's Mental Health

II

Approximately 25% of American men and women ages 18 years and older suffer from a diagnosable mental disorder in a given year, and approximately 6% of adults suffer from a serious mental illness (NIMH).

While the overall numbers of men and women with mental illness are similar, research in recent years has highlighted important gender differences in the "risk, prevalence, presentation, course, and treatment of mental disorders" (Surgeon General, 2005). For example, women experience depression at twice the rate of men, and women are much more likely to experience an anxiety disorder. One in five women will experience an episode of major depression during her lifetime, and one in three will experience an anxiety disorder (Misra, 2001). Women are more likely than men to have physical and psychological symptoms of stress (American Psychological Association, 2008).

Women disproportionately experience a number of risk factors for common mental disorders, including

— **Gender-based violence**

— **Socioeconomic disadvantage**

— **Low income/income inequality**

— **Low or subordinate social status and rank**

— **Unremitting responsibility for the care of others** (WHO, 2008)

WOMEN AND MENTAL HEALTH

Overall rates of psychiatric disorders are almost identical for men and women.

However, striking gender differences are found in the patterns of mental illness.

(WHO, 2008)

GENDER DIFFERENCES IN MENTAL DISORDERS

- **Depression — Major depression is one of the most common of all psychiatric disorders. Twice as many women as men experience depression in their lifetime.**
- **PTSD — Risk of post-traumatic stress disorder following traumatic experiences is two-fold higher in women than men. Women experience markedly worse quality of well-being outcomes than men.**
- **Anxiety/panic disorder — Women are twice as likely as men to experience an anxiety disorder.**
- **Suicide — Women attempt suicide two to three times more often than men; however, four times as many men as women die by suicide.**
- **Eating Disorders — 85%–95% of people with anorexia nervosa or bulimia are women.**
- **Schizophrenia — Men and women are affected with equal frequency; however, it often first appears in men in their late teens or early twenties, while women are generally affected in their twenties or early thirties.**
- **Substance use disorders — Women are more likely than men to experience co-occurring mental health and substance use disorders.**

(Burt and Stein, 2002; Lepine, 2002; Weissman and Olfson, 1995; NIDA, 1998; NIMH; WHO, 2008)

Mental illness also imposes a tremendous burden on society:

— **Mental illness accounts for more than 15% of the burden of disease in the United States—more than the disease burden caused by all cancers** (Surgeon General, 1999).

— **Mental disorders are the leading cause of disability in the United States for people ages 15–44 (WHO, 2004)**

— **In the United States, all physical conditions cause 2.4 billion disability days each year, and mental conditions cause 1.3 billion disability days each year** (Merikangas et al., 2007).

Influences on Women's Mental Health

Many factors can contribute to differences in men's and women's mental health. Four general categories include:

— **Biological**

— **Situational**

— **Psychosocial**

— **Cultural**

Important biological differences related to hormones and brain structure may affect mental health risks, rates of disorders, and the course of those disorders. For example, research has demonstrated that estrogen and progesterone influence brain function and stress response. Some women experience increased vulnerability to depression during times of reproductive endocrine changes, such as the premenstrual, puberty, postpartum, and menopausal periods.

Psychosocial factors can contribute to women's higher risk of mental health issues, particularly depression. Women's lower socioeconomic status, exposure to stressful events, work overload, role conflict, and victimization can contribute to greater risk (Desai and Jann, 2000; Mayo Clinic, 2008a).

DEFINITION: MENTAL HEALTH VS. MENTAL ILLNESS

Mental Health

- **Successful performance of mental function throughout the life cycle, resulting in:**
  - Productive activity
  - Fulfilling relationships
  - Ability to adapt to change and cope with stress
- **Foundation for thinking, communication skills, learning, emotional growth, resilience, healthy relationships, and self-esteem**

Mental Illness

- **Health conditions characterized by changes in:**
  - Thinking
  - Mood
  - Behavior (or some combination of these three)
- **Associated with distress and/or impaired functioning**

In the context of mental health and treatment, culture can influence how women communicate, how they manifest symptoms and explain illnesses, how they cope, how willing they are to seek treatment, and the type of family and community support they receive.

Of note is the importance of women's mental health not only to their own overall health, but also to the health and well-being of those around them. Women make three-fourths of the health care decisions in American households, whether for a family member or themselves (DOL, 2008).

MENTAL DISORDERS ARE MORE COMMON AMONG YOUNGER WOMEN

Age	Serious psychological distress	Depression (MDD)
18–25	**23%**	**13%**
26–49	**16%**	**10%**
50+	**9%**	**7%**

(HRSA, 2007)

III

Status — Part A: Gender Differences in Specific Mental Health Disorders

Depression

Major depression is the second most common condition (after hypertension) seen in primary care (Sartorius et al., 1996). Depression is significantly more common among women than men. Major epidemiological studies have found an average lifetime prevalence of depression of approximately 20% for women and 10% for men (Desai and Jann, 2000).

Without treatment, depressive disorders characteristically assume a chronic course. Globally, depressive disorders are the third leading cause of burden of disease for all ages and the leading cause of disease burden for women ages 15 to 44 (WHO, 2004). Major depression also increases the risk of heart attack (NIMH). Heart attack is the leading cause of death among US women.

WOMEN, STRESS, AND DEPRESSION: SUPERWOMAN SYNDROME

- **Taking care of everyone**
- **Taking on too many commitments**
- **Difficulty setting limits and saying "no"**
- **Feeling guilty when saying "no"**

Often this behavior is culturally accepted, expected, and encouraged, especially among women of color.

Similar to the influences on overall mental health discussed above, the higher rate of depression in women is likely due to "a combination of gender-related differences in cognitive styles, certain biologic factors, and a higher incidence of psychosocial and economic stresses in women" (Bhatia and Bhatia , 1999). For example, hormonal changes can increase vulnerability in some women. Likewise, the stress associated with increased expectations and responsibilities (superwoman syndrome), role overload, and role conflict can be a set-up for exhaustion and depressive symptoms.

Women who experienced abuse as children (emotional, physical, sexual) and women who experienced sexual assault or abuse as teenagers or adults are at greater risk of experiencing depression during their lives (Mayo Clinic, 2008a). Other risk factors for depression among women include lower socioeconomic status and being a single mother. In addition, women with depression have higher rates of comorbidity than men, particularly with anxiety disorders, somatization, and eating disorders (Desai and Jann, 2000).

Men and women often experience depression differently. For example, women

— **May experience more persistent depression than men** (WHO, 2008)

— **Experience greater symptom severity, but fewer episodes of major depression than men** (Marcus et al., 2008)

— **More frequently experience bodily symptoms, such as fatigue, appetite, and sleep problems** (Silverstein, 2002; Barsky, Peekna, and Borus, 2001)

— **Experience greater seasonal effects on mood than men** (Leibenluft, Hardin, and Rosenthal, 1995)

Depression is often underrecognized and undertreated. It is misdiagnosed 30% to 50% of the time (Desai and Jann, 2000). There are differences in diagnosis and treatment among men and women. Antidepressant use among women is twice that of men (CDC, 2007) and more than half of women with depression use complementary and alternative treatments (Wu et al., 2007).

Depression can be associated with specific times during women's lifetime reproductive cycle, and there is accumulating evidence that reproductive-related hormonal changes put some vulnerable women at increased risk for depression. Women are at increased risk with the onset of puberty. Many women experience some emotional symptoms premenstrually; approximately 5% are diagnosed with premenstrual dysphoric disorder, which can involve depression, anxiety, irritability, and cognitive and physical symptoms. Women with a history of depression may be at greater risk during pregnancy, particularly if psychotropic medications are discontinued (Burt and Stein, 2002). An increased risk of depression is also associated with the perimenopausal period and with infertility, miscarriage, or perinatal loss.

Postpartum depression is experienced by some 10% to 15% of new mothers. The baby blues (a short-lasting condition that does not require medical intervention) are experienced by up to 70% of all new mothers. Postpartum depression is distinguished from the baby blues both by its duration and its debilitating effects (Office of Women's Health, 2008).

Depressive episodes can be triggered by season of the year, and women are more affected than men. Three times as many women as men experience seasonal affective disorder (Leibenluft, Hardin, and Rosenthal, 1995).

Suicide

Suicide is the 11th leading cause of death in the United States. More than 6,000 women die each year from suicide (CDC, 2008). Women are much more likely than men to attempt suicide. However, men are almost four times more likely to die as a result of suicide, at least in part because of their use of more lethal methods (NIMH).

White women are at greater risk of suicide than Hispanic, Asian, or African American women, and there has been an increase in suicide among middle-aged white women in recent years, according to a study of nationwide data from the Centers for Disease Control and Prevention (CDC, 2008; Hu et al., 2008). Elderly and young Asian women (ages 15-24) have relatively high rates of suicide, while African American women have lower rates (CDC, 2008).

SUICIDE

The fourth leading cause of death among girls/women ages 15–24 years

The sixth leading cause of death among 10– to 14–year–old girls

(CDC, 2008)

Risk factors for suicidal attempts among women include the following (Bhatia and Bhatia, 1999):

— **Younger than 30 years**

— **Threatened loss of intimate relationship**

— **Living alone**

— **Current psychosocial stressors (e.g., recent loss of job)**
— **Substance abuse**
— **Personality disorder (e.g., borderline personality disorder)**
— **Clinical depression**

Anxiety/PTSD

Women are more likely than men to have an anxiety disorder. While a certain degree of anxiety can be normal, an anxiety disorder is diagnosed when worry is pervasive, irrational, the person knows it is irrational, and the condition disrupts normal life and relationships. At any given time, an estimated 13% of women have an anxiety disorder, compared with 6% of men. One in three women will experience an anxiety disorder in her lifetime (Lepine, 2002). Among the specific anxiety disorders that affect women more than men are panic disorder, post-traumatic stress disorder (PTSD), generalized anxiety disorder, agoraphobia, and specific phobia (WHO, 2008). Women may express their anxiety in terms of physical symptoms such as headaches, lightheadedness, muscle tension, or other stress-related symptoms.

Even though men are more likely to experience a traumatic event, women are nearly twice as likely to be diagnosed with PTSD. The most common cause of PTSD in women is sexual trauma, while the most common cause in men is combat. Thus, the type of trauma experienced may partially explain the higher rates of PTSD among women. However, a review of 25 years of research found that the type of trauma accounted for some but not all of the difference (Tolin and Foa, 2006). The difference in rates of occurrence in men and women may be related, in part, to differences in the way men's and women's brains process emotions and actions (National Women's Health Center, 2008).

MEN AND WOMEN DIFFER IN HELP SEEKING

- **Consultation rates and help-seeking patterns in men are consistently lower than in women, especially in the case of emotional problems and depressive symptoms.**
- **Women are more likely to seek help from and disclose mental health problems to their primary health care physician.**
- **Women are less likely than men to seek specialist mental health care, and men are the principal users of inpatient care.**
- **Women are less likely than men to disclose problems with alcohol use to their health care provider.**

Despite these differences, most women and men experiencing emotional distress and/or psychological disorder are neither identified nor treated by their doctor.

(Alvidrez, 1999; Mackenzie, Gekoski, and Knox, 2007; Möller-Leimkühler, 2002; WHO, 2008)

Eating Disorders

Women are much more likely than men to develop an eating disorder (anorexia nervosa, bulimia nervosa, or binge eating). An estimated 0.5% to 3.7% of females will suffer from anorexia nervosa, and an estimated 1.1% to 4.2% will suffer from bulimia during their lifetime. Eating disorders often start in the teenage years, and people with eating disorders tend to suffer from other mental disorders such as depression, anxiety, or substance use disorders (NIMH). An estimated 90% of those who have eating disorders are women between the ages of 12 and 25. People with eating disorders tend to withdraw from social contact and hide their eating behavior, making it one of the psychological problems least likely to be treated.

Interconnectedness of Health and Mental Health

Health and mental health are inextricably connected. More than half of Americans believe that one cannot have good physical health without good mental health (American Psychological Association, 2005). Understanding the relationship between mental disorders and physical health issues is key to public health assessment and health care delivery. A few examples illustrate the connection between physical health and mental health:

— **Some studies have found that both men and women experience decreased depression symptoms with increased cardiorespiratory fitness** (Galper et al., 2006).

— **People with chronic somatic diseases are more likely to have mental disorders than people without chronic diseases** (Harter et al., 2007).

— **People with mental illness have a higher rate of cardiovascular mortality** (Surtees et al., 2008).

— **People with poor mental health scores seem to report more physical limitations than would be expected based on physical performance** (Ruo et al., 2008).

— **Eating disorders contribute to physical problems such as anemia, hair and bone loss, and tooth decay.**

IV

Status — Part B: Special Populations of Women

Clearly, women are not a homogeneous population. This section identifies some specific subpopulations of women and briefly describes some of the mental challenges each of them face.

— **Ethnically and racially diverse populations (African American, Latino, Native American, and Asian American)**

— **Poor and disadvantaged**

— **Incarcerated**

— **Immigrant populations**

— **Developmentally and physically disabled**

— **Primary caregivers**

— **Older women**

— **Military personnel and families**

— **Rural**

— **Domestic violence/history of childhood abuse**

DISPARITIES IN MENTAL HEALTH CARE

People of color

- **Are less likely to receive services**
- **Receive poorer quality of care**
- **Are underrepresented in mental health research**

(Surgeon General, 2001)

Ethnically and Racially Diverse Populations

A 2001 report from the US surgeon general, "Mental Health: Culture, Race and Ethnicity," concluded that "ethnic and racial minorities in the U.S. face a social and economic environment of inequality that includes greater exposure to racism, discrimination, violence, and poverty, all of which take a toll on mental health." The impact of poverty is measurable, the report notes: people in the lowest strata of income, education, and occupation are about two to three times more likely than those in the highest strata to have a mental disorder.

While much effort has been focused in recent years on identifying and reducing disparities in health care, a recent study of depression treatment found that "disparities in access to and quality of care for ethnic and racial minority populations remain a critical issue in mental health care" (Alegria et al., 2008). African Americans, Latinos, and Asian Americans were all less likely than whites to receive any mental health treatment, even after adjusting for socioeconomic variables (e.g., poverty, insurance, education). Among those with past-year depression, 69% of Asians, 64% of Latinos, and 59% of African American did not access any treatment, compared with 40% of whites. Among the possible reasons for the disparity identified by the researchers were differences in presentation of symptoms of depression, stigma of mental illness among minorities, mistrust of mental health system/professionals, and an inadequate supply of mental health services (Alegria et al., 2008).

Another study looked at trends over ten years, specifically in mental health treatment among African American and Latinos in both primary care and by psychiatrists. The study found reduced disparities in psychiatric care but continued disparities in mental health care in primary care visits (diagnoses, counseling/referrals for counseling, antidepressant medication) among African Americans and Latinos (Stockdale et al., 2008).

Race, ethnicity, and culture can influence an individual's mental health in a number of ways: in the understanding of illnesses and causes, in experience and communication of illnesses and symptoms, in help-seeking behaviors, in types and extent of family and community support, in the stigma and shame associated with mental illness, and in the way doctors interact with the individual. One recent study found that African-American, Hispanic, and Asian-American women were significantly less likely to use specialty mental health services than white women (Kimerling and Baumrind, 2005). In addition, African-American and Asian-American women were less likely to seek mental health services.

African American

There are a number of differences in the mental health experiences of African American women and women of other ethnicities—some showing a greater risk or vulnerability and some appearing to indicate a greater resilience or protection.

Despite the social and economic inequities that many African American women face, rates of depression are lower among African American women than among Hispanic and white women (Surgeon General, 2005). These differences raise questions about the social or protective factors that may be involved in fostering the lower rates.

African American women with depression are less likely than whites to receive treatment for mental health problems and are more likely to use emergency services or primary care providers rather than mental health specialists (Office of Women's Health). African Americans are misdiagnosed more often, are more likely to drop out of services, and use fewer treatment sessions for mental health services than whites. African Americans with depression are also much less likely to take medication for depression than whites (MHA, 2003). Among the factors influencing treatment rates may be less trust in the medical community, lack of insurance, and inability to get to a doctor. Some women may rely on their friends or religious community for support instead of seeing a doctor.

MAJOR RACIAL/ETHNIC GROUPS IN US

- **Latinos/Hispanics – 15%**
- **African Americans – 13%**
- **Asian American/Pacific Islanders – 5%**
- **American Indians/Alaska Natives – 1.5%**
- **Other – 7%**

(US Census, 2007)

Latino

The US Hispanic/Latino community is made up of people from many different nations and races. While many have lived in the United States for generations, others are recent immigrants. Although Hispanics/Latinos often quickly become part of mainstream US culture, many still face inequities in socioeconomic status, education, and access to health and human services. Recent studies have shown that mental health programs are not always successful in reaching Hispanics/Latinos in need of mental health care. Nationally, 33% of Hispanics are uninsured, compared with 16% of all Americans (US Census, 2008) Many Hispanics/Latinos rely on their extended family, community, traditional healers, and/or churches for help during a mental health crisis.

IV

One recent study found that the risk of most psychiatric disorders was lower for Latinos than whites, and the rates for most disorders were higher for US-born Latinos than for Latino immigrants. However, the rates varied among Latino subgroups (Alegria et al., 2008). For example, Puerto Ricans had the highest overall rate of mental illness among the Latino ethnic groups assessed, and Puerto Rican women were at greater risk of depression and had low rates of help seeking (Alegria et al., 2007a; Stacciarini, 2008). In addition, rates of mental health service use among Latinos have increased substantially in the past decade (Alegria et al., 2007b).

American Indians and Alaska Natives

Research on mental health among American Indians/Alaska Natives (AI/ANs) is limited by the small size of this population and by its heterogeneity. Nevertheless, studies suggest that youth and adults suffer a disproportionate burden of mental health problems and disorders. The most significant mental health concerns among AI/ANs today are substance abuse, depression, anxiety, violence, and suicide (SAMHSA, 2002). AI/AN women are significantly more likely to be victims of physical assault, rape, and stalking than women of other racial/ethnic backgrounds (Tjaden and Thoennes, 2000).

The availability of mental health services is severely limited by the rural, isolated location of many AI/AN communities. Most clinics and hospitals of the Indian Health Service are located on reservations, yet the majority of American Indians no longer reside on reservations. In addition, approximately 30% of AI/ANs are without insurance (US Census, 2008).

Among AI/AN people, the concept of mental illness has different meanings and interpretations, and "beliefs about why and how illness develops differ widely across North America; spiritual elements are common" (Lim, 2006). Some studies have shown that physical complaints and psychological concerns are often not distinguished (NAMI, 2003). Use of traditional healers is common among some AI/ANs. For example, a study of one Southwest tribe found that men and women meeting the criteria for depression/anxiety or substance use disorders were significantly more likely to seek help from a traditional/spiritual healer than from medical sources (Beals et al., 2005).

CULTURAL INFLUENCES ON MENTAL ILLNESS AND MENTAL HEALTH

- **Communication (verbal and non-verbal)**
- **Manifestation of symptoms**
- **Family and community support**
- **Help-seeking behaviors**
- **Support systems and protective factors**
- **How people perceive and cope with mental illness**
- **How doctors interact with people with mental illness**
- **Stigma and shame associated with mental illness**
- **Spirituality (predestination, views of illness, etc)**

(Surgeon General, 2001)

Asian American/ Pacific Islanders

Asian Americans and Pacific Islanders (AA/PIs) are a highly diverse group, consisting of at least 43 ethnic groups. Research suggests that the overall prevalence of mental health problems and disorders among AA/PIs does not significantly differ from the prevalence for other Americans (Meyers, 2006). Because

of the group's diversity, there are many differences in mental health experiences and needs. For example, refugees from Southeast Asian countries are at greater risk for PTSD as a result of the trauma and terror preceding their immigration. The suicide rates of Asian American women in two specific age groups are significantly higher than those of other women in those age groups: the elderly and 15- to 24-year-olds (CDC, 2008). Asian Americans, particularly women, have lower rates of substance use disorder than other racial/ethnic groups (SAMHSA, 2002).

Asian Americans utilize mental health services less than other populations; one study found that only 4% would seek help from a mental health specialist, compared with 26% of whites (Zhang, Snowden, and Sue, 1998). US-born Asians use services at a higher rate than foreign born, and third generation or later had higher rates of service use than first and second generation (Abe-Kim et al., 2007). Many Asian Americans may seek traditional treatment (e.g., herbal medicine) before seeking help through Western medicine sources (Lim, 2006).

Poverty

There is a strong correlation between poverty and poor mental health: People in the lowest socioeconomic strata are more than twice as likely as those in the highest strata to have a mental disorder (Surgeon General, 2001). The poverty rate for women (12.5%) is about 40% higher than the poverty rate for men (8.8%). The poverty rates for African Americans, Hispanics, and Native Americans are more than 20% each. The poverty rate for female-headed households is 28%, compared with 5% for married couples and 13 percent for male-headed households (US Census, 2008).

The reasons for the association between lower socioeconomic status and mental illness are not well understood. According to the surgeon general, a combination of greater stress in the lives of poor people and greater vulnerability to a variety of stressors may lead to some mental disorders (Surgeon General, 2001). In addition, people with serious mental illness are more likely to be poor.

Incarceration

In 2006, there were more than 1.3 million women inmates, parolees, and probationers in the United States—about 18% of the total number of inmates, parolees, and probationers in the United States (Glaze and Bonczar, 2006). According to the federal Bureau of Justice Statistics (BJS), more than half of the people in jail and prison in the United States have a mental health problem, and female inmates had higher rates of mental health problems than males (73% to 75% of women; 55% to 63% of men). The BJS also found that state inmates with mental health problems were twice as likely to have been homeless before arrest as other inmates (James and Glaze, 2006). Additionally,

— **More than half of women inmates were the mothers of minor children** (Glaze and Maaruschak, 2008).

— **African American women were incarcerated at nearly 4 times the rate of white women, and Hispanic women were incarcerated at nearly 1.6 times the rate of white women** (Sabol, 2007).

— **Nearly eight out of ten female offenders with mental illness reported having been physically or sexually abused** (Smith, 1998).

— **Inmates with major mental illnesses are at much greater risk of multiple incarcerations than those without mental illnesses** (Baillargeon et al., 2008).

Immigrant Populations

Immigrants often face numerous difficulties and stresses, such as adapting to a new culture, separation from loved ones, language barriers, poor living conditions, and trauma experienced in their homeland. As a result of these stressors, immigrants may be at a higher risk for mental/emotional problems—particularly depression, anxiety, post-traumatic stress, and substance abuse. However, Alegria and colleagues (2008) found that immigrants seem to benefit from a protective context and increased resilience from their country of origin, particularly if they came to the United States as adults. They found that Mexican immigrants had lower rates of mood, anxiety, and substance use disorders than their US-born Mexican American counterparts. Another study of Asian American women found lower rates of mental disorders in immigrant Asian American women than among US-born Asian American women (Takeuchi et al., 2007).

Immigrant women often face a number of barriers to accessing mental health services, including language difficulties, being unfamiliar with or unaware of services, gender roles, and socioeconomic status. The health care relationship between providers and women can affect whether immigrant women seek help for mental health problems (O'Mahahony and Donelly, 2007). In addition, immigrants' circumstances and the fear of arrest, detention, or deportation can deter them from seeking assistance and services.

Developmentally and Physically Disabled

Research over many years has found that the prevalence of mental illness among those with an intellectual disability is at least as common as it is in the general population, and some specific diagnoses are more common (Kerker et al., 2004). Adults with intellectual disabilities were reportedly diagnosed more often with anxiety and psychotic disorders than members of the general population. Among adults with intellectual disabilities, depression and schizophrenia were more common in women; behavior disorders and autism spectrum disorders were more common in men (Bhaumik et al., 2008). One of the difficulties in identifying and treating individuals is that health care providers have difficulty diagnosing mental health conditions among individuals with intellectual disabilities. For example, communication difficulties and symptoms of mental disorders were often attributed to intellectual disability (Kerker et al., 2004).

Any type of disability appears to contribute to higher risk of victimization, but intellectual disabilities, communication disorders, and behavioral disorders appear to contribute to very high levels of risk—and having multiple disabilities results in even higher risk levels (Davis, 2005). People with intellectual disabilities are four times more likely than other Americans to be targets of sexual assault and other violence (Sobsey, 1994).

People with physical disabilities or chronic health conditions are also at greater risk of mental health problems. A study of older adults with chronic medical conditions concluded that "it is not the nature of the condition that determines psychological distress, but instead the severity of the disability and loss of psychological resources associated with the condition on the one hand and the psychological characteristics of the patient on the other" (Ormel et al., 1997).

Caregiving

Informal caregiving by women is an essential part of the current system of long-term care. Families provide as much as 80% of the care to elderly and disabled people (Dentinger and Clarkberg, 2002). Women provide the majority of informal care to spouses, parents, parents-in-law, friends, and neighbors, and they play many roles while caregiving: hands-on health care provider, care manager, friend, companion, surrogate decision maker, and advocate (Navaie-Wallser et al., 2002). The value of the informal care that women provide is estimated between $115 billion and $288 billion annually, significantly higher than estimates for formal caregiving (home health and home nursing care) (Arno, Levine, and Memmott, 1999). Nationally, according to the Family Caregiver Alliance and findings by the National Alliance for Caregiving and AARP,

— **More than 60% of caregivers are women.**

— **The average caregiver is age 46, female, working outside the home, earning an annual income of $35,000.**

— **Female caregivers may spend as much as 50% more time providing care than male caregivers and provide a higher level of care than male caregivers.**

— **Women are more likely than men to say they felt they did not have a choice in taking on the caregiving responsibility.**

Caregiving can take an enormous toll on the caregiver. Higher levels of depression, anxiety, and other mental health challenges are common among women who care for a disabled relative or friend. Studies of women's caregiving experience have found the following:

— **Women who provided 36 or more hours per week of care to a spouse were almost six times as likely to suffer depressive or anxious symptoms as were those who had no caregiving responsibilities** (Cannuscio et al., 2002).

— **Women caring for ill parents were twice as likely to suffer from depressive or anxious symptoms as noncaregivers** (Cannuscio et al., 2002).

— **Women caregivers consistently experienced more psychiatric problems than men caregivers** (Yee and Schulz, 2000).

— **Women caregivers felt greater hostility and less happiness after becoming caregivers** (Marks, Lambert, and Choi, 2004).

Caregivers can benefit from a range of support services to help them remain healthy, improve caregiving skills, and remain in their caregiving role with less stress and greater satisfaction (Whittier, Coon, and Aaker, 2002). Caregiver support services include information, assistance, counseling, respite, home modifications or assistive devices, support groups, and family counseling. Women are more likely than men to talk with friends and family as a way of coping with caregiving stress (National Alliance for Caregiving and AARP, 2004).

IV

Older Women

There are more older women than men: at 60 to 65 years old, there are 114 women for every 100 men, and among those 85 and older, there are more than 210 women for every 100 men.

The most common disorders among older adults are anxiety, severe cognitive impairment, and mood disorders. While overall prevalence of mental disorders among women decreases with age, older adults with mental health problems are less likely than younger adults to seek treatment. More than half of older persons who do receive mental health care receive it from their primary care physicians (AAGP, 2008).

And while the prevalence of major depression declines with age, depressive symptoms increase. More than 30% of older adults in primary care settings suffer from depressive symptoms (AAGP, 2008). One study of elderly women's use of mental health services concluded that the high use of medical care and low use of mental health care by older women may be due at least in part to some women misinterpreting mental health symptoms as medical problems (Wiltshire, McQuirter, and Taylor, 2005).

Military Personnel and Families

A growing number of military personnel and their families are reporting emotional problems resulting from deployment stress, according to a 2007 report from the American Psychological Association. More than 30% of all soldiers met the criteria for mental disorder, but fewer than half (23% to 40%) of those with mental health concerns sought help. The most common problems among veterans are alcohol problems, depression, and anxiety problems, including PTSD (Murphy, Iversen, and Greenberg, 2008). Similarly, an American Psychiatric Association survey found that 38% of military members and 39% of military spouses experienced anxiety at least twice a week, and 40% of military members and 33% of military spouses experienced feelings of depression at least twice a week.

Women in the military face additional challenges. A review of numerous studies of military women found very high rates of sexual harassment (55% to 79% in active-duty military) and of sexual assault (4% to 7% in active-duty military, and 11% to 48% among veterans). Like men, women veterans were more likely to be homeless than the general population, and of those, the women were more likely than men to be diagnosed with a major psychiatric disorder and less likely to be diagnosed with a substance use disorder (Goldzweig et al., 2006).

Spouses of deployed military personnel also face a number of stresses while the spouse is deployed as well as upon his or her return. Not surprisingly, research has shown that spouses of veterans with PTSD have higher rates of psychological and marital distress and domestic violence than do spouses of veterans without PTSD (Renshaw, Rodrigues, and Jones, 2008).

Rural

The poverty rate in rural areas is higher than in metropolitan areas, and poverty rates among minorities are much higher than among whites. Rural families headed by women have the highest poverty rates of all family types—more than 40% (Snyder and McLaughlin, 2004).

Women in rural areas are more likely to suffer from mental disorders and less likely to receive treatment than other women. Some studies have found rates of depressive symptoms among rural women around 40%, compared with 13% to 20% among urban women. Risk factors for mental health problems among rural women include isolation, higher rates of poverty, domestic violence, lack of education and economic opportunity, and high levels of physical stress (Rural Assistance Center, 2007).

Rural women are less likely than women in urban/suburban areas to receive mental health treatment through either the general health care system or the specialty mental health systems (Hauenstein et al., 2006). Hauenstein concluded that there is a considerable unmet need for mental health services in most rural areas, and the general health sector does not seem to contribute remarkably to mental health services for women in these areas.

Access barriers to treatment which may be greater for rural women include lack of transportation, lack of child care, poverty, lack of health insurance, and lack of mental health providers. Some 60% of rural areas are designated as federal Mental Health Professional Shortage Areas (American Psychological Association, 2008). In addition, cultural and social factors—for example, gender roles—and perceptions about the causes and symptoms of mental illness may also inhibit women from seeking treatment (Hauenstein, 2003).

Domestic Violence/Abuse

Violence against women, and particularly domestic violence and intimate partner violence, is a pervasive problem, although it is often not recognized or addressed. According to the National Violence Against Women Survey (Tjaden and Thoennes, 2000),

- **52% of women reported being physically assaulted during their lifetime.**
- **22% of women had been physically assaulted by a partner or date during their lifetime.**
- **17% of women have been the victim of an attempted or completed rape in their lifetime, 8% by a current or former partner.**
- **8% of women were stalked in their lifetime.**
- **64% of women who reported being raped, physically assaulted, and/or stalked since age 18 were victimized by a current or former husband, cohabiting partner, boyfriend, or date.**
- **Approximately 1.9 million U.S. women are physically assaulted annually.**

There is a strong connection between women's experiencing serious mental illness and domestic abuse. Victims of domestic abuse are at much increased risk for mental illness and substance use disorders. Numerous studies of abused women have found significantly increased rates of depression (63% to 77%), anxiety (38% to 75%), and PTSD (54% to 84%) (DVMHPI, 2008). From the other perspective, a review of a number of studies of women with serious mental illness found that between 51% and 97% had experienced physical and/or sexual

abuse (Goodman et al., 1997). Numerous studies also link substance abuse, somatoform disorders, eating disorders, and psychotic episodes to adult or childhood abuse (DVMHPI, 2008). Although a history of trauma and abuse and serious mental illness are strongly correlated, the relationship is complex and potentially reciprocal (Goodman et al., 1997).

Childhood abuse can have long-lasting mental health effects (Edwards et al., 2003). Failure to identify and address issues of violence leaves victims at greater risk of both more violence and long-term poverty (Johnson and Meckstroth, 1998). An important factor limiting identification and treatment of women victims is women's reluctance to talk about violent victimization. The three most cited reasons by women victims for not reporting the domestic violence are considering it a private or personal matter, fear of reprisal, and a wish to protect the offender (Catalano, 2007).

Barriers/Obstacles to Care and Protective Factors

V

There are many reasons women do not receive help for mental health problems, and while many of the reasons are similar among men and women, there are some differences. For both men and women, the top reasons identified in a nationwide study were cost/no insurance, feeling they could handle the problem without treatment, and stigma (see table 1).

The participants in APA 2007 Women's Mental Health Roundtable were asked to identify the top obstacles/barriers to women's mental health. The top four barriers identified were

- **Stigma/lack of awareness and knowledge**
- **Lack of access to mental health care**
- **Parity/lack of insurance**
- **Cultural competence/physician training**

Focus groups held by APA in 2005 identified some additional issues relating to women's perception of mental health, mental illness, and treatment (Riba, 2005). Many women still feel that needing help represents a personal failing or loss of control. Many women will not use the phrase "mental illness" and tend to shift to using "mental health concern" or "emotional problem."

TABLE 1: REASONS FOR NOT GETTING MENTAL HEALTH TREATMENT OR COUNSELING BY WOMEN AND MEN NEEDING IT

Reason for Not Receiving Services	Women	Men
Cost/no insurance	47%	52%
Feeling could handle without treatment	34%	29%
Stigma, (others' opinions, effect on employment, shame, embarrassment, fear)	20%	24%
Did not know where to go for services	19%	17%
Did not have time	15%	11%
Did not think treatment would help	9%	10%
Fear of being committed/having to take medicine	8%	11%

Source: Health Resources and Services Administration, HHS. "Women's Health USA." 2007

V

Stigma

While public knowledge and understanding of mental illness has increased, stigma against people with mental illness still plays an important role in people's attitudes and behaviors relating to mental illness. Stigma involves labeling someone with a condition, stereotyping people who have that condition, and discriminating against someone on the basis of their label (Mayo Clinic, 2008b). Stigma is displayed in bias, distrust, stereotyping, fear, embarrassment, anger, and/or avoidance.

Stigma leads others to want to avoid socializing or working with people with mental disorders, especially severe disorders such as schizophrenia (Corrigan and Penn, 1999; Penn and Martin, 1998).

Despite increased public knowledge and understanding of mental illness and a greater awareness that it can happen to anyone, negative social responses and misperceptions persist (e.g., that people with mental illness are more violent) (Gordon et al., 2004). According to a 2004 survey by the American Psychological Association (2005),

— **Almost 50% of Americans think the stigma of seeking mental health services has decreased.**

— **25% say they would be less concerned about someone finding out they had been seeing a mental health professional than they would have been five years earlier.**

— **20% might choose not to seek help from a mental health professional because they feel there is a stigma associated with therapy.**

— **30% say they would be concerned about other people knowing they saw a mental health professional.**

— **91% are likely to consult or recommend that a family member consult with a mental health professional.**

Stigma is greater among men than women, and that difference is evident even among teens (Chandra and Minkovitz, 2006). In a study of men, women, and stigma, both men and women felt less stigma when they had more knowledge of mental illness and treatment. However, women who had family or friends with a mental illness felt less stigma than those who did not; this relationship was not true for men (Wang et al., 2007). As more people understand that mental disorders are not the result of character flaws or moral failing but are legitimate illnesses that can be treated, the effects of stigma should decrease.

Access to Care

Among the numerous barriers to care for women are

— **Cost/insurance (discussed in the next section)**

— **Lack of knowledge about mental illness (causes, symptoms, etc.)**

— **Lack of knowledge about types and availability of services/treatment**

— **Geographic and logistic barriers (remote location, homebound, disability, child care or elder care responsibilities, lack of time because of work or other obligations)**

— **Language/cultural barriers (lack of trained mental health professionals able to deliver culturally appropriate services meeting the patient's social, cultural, and linguistic needs)**

— **Stigma (discussed in previous section)**

Potential barriers differ among different groups of women. In one study, barriers to accessing substance abuse treatment programs reported by African Americans (child care, affordability, and identifying services) differed some from barriers reported by their white counterparts (stigma and perception of ineffectiveness of care) (Tonigan, 2003). Hispanics use mental health services far less than other ethnic and racial groups. While cost/insurance plays a large role, culture and language are also significant barriers. The lack of interpreters and bilingual professionals can interfere with appropriate evaluation, treatment, and emergency response. Hispanics/Latinos often have different attitudes about accessing mental health services and may feel highly stigmatized for doing so. Some evidence suggests that Asian Americans access mental health services when they are more severely ill than other groups and may delay seeking treatment because of stigma associated with mental illness and because of cultural and linguistic barriers (Meyers, 2006).

Perceived need and decisions to seek services are other important factors in access to care, and there are differences among racial and ethnic groups. People may not recognize their symptoms as those that could benefit from mental health care. In a 2005 report by Kimerling and Baumrind (2005), Asian American and Hispanic women were less likely than white women to perceive the need for services. African American and Asian women were less likely than white women to seek mental health services after difference in insurance status had been taken into account. Among women who sought services, Hispanic women were less likely than white women to obtain services after adjustment for the effects of poverty. Overall only 58% of women who reported perceived need sought mental health services.

According to a report from the National Mental Health Association (2003), one of the largest barriers to treatment for women with serious mental illness who have children is leaving their children in the care of relatives or in the foster care system, as they fear losing permanent custody of their children. The report also notes the conflict between children being a primary source of motivation for treatment and concern about the safety and care of children being a primary reason for poor retention rates in treatment.

Cost/Insurance

Untreated mental health disorders cost American businesses $79 billion in lost productivity per year (Surgeon General, 1999). Nearly 18% of women ages 18 to 64—or more than 17 million women—lack health insurance (Kaiser Family Foundation, 2008). Without insurance, women with mental health needs are less likely to be able to access services. Adults with mental health coverage are more likely to receive mental health services from both general medical and specialty mental health providers and to receive care consistent with clinical practice guidelines than those with no health insurance or with insurance that does not cover mental health conditions (Sturm and Wells, 1995; Institute of Medicine, 2004).

A survey of community health centers found that more than 40% of uninsured patients had difficulty (rarely or never able) obtaining specialty mental health services, and more than 50% had difficulty accessing substance abuse services. Even patients with Medicaid had difficulty obtaining services: more than 20% for mental health services and more than 30% for substance abuse services (Cook et al., 2007).

Uninsured adults with severe mental illness receive less appropriate care or medications and experience delays in receiving services (McAlpine and Mechanic, 2000; Rabinowitz et al., 1998, 2001). And even with insurance, the costs associated with treatment can be extensive—for example, transportation, child care, copays, lost work time.

While most women have insurance through an employer or public programs, those who use private insurance often face additional difficulties. A study by the National Women's Law Center found that in the individual insurance market, women are often charged higher premiums than men, and maternity care is often not covered.

Women and Men Differ on Service Delivery Needs

Women and men express similar needs and desires for specific mental health services but differ in their concepts of respect and the process for delivery of services, according to research by Scheyett and McCarthy (2006). Among the components of mental health services that both men and women identified as important were

— **Peer support**

— **Evidence-based practices**

— **Focus on recovery, including an emphasis on hope for the future**

— **A relationship with a mental health provider based on mutuality and respect**

Women and men differed, however, in their conceptualizations of respect (Scheyett and McCarthy, 2006). For men, "respect meant being listened to, being given information, and being supported in moves toward greater independence." For women, respect meant "caring, understanding, and mutual relationship with the provider." In addition, women were more concerned than men with the larger frame of the mental health system. The women were bothered by the lack of coordination in mental health and other services and wanted support in dealing with the system. In summary, "although some of the what of service needs may be similar for men and women, the where and how differ in important ways."

Another study looking at differences among men and women in the use of mental health services found that women were more likely than men to use the specialty mental health sector and were more likely to take psychotropic medications (Freiman and Zuvekas, 2000). The researchers concluded that the differences may reflect patient preferences, but may also reflect biases and misperceptions on the part of patients and providers.

Particularly for women with comorbid mental health and substance abuse issues, research suggests a number of benefits for treatment specific to women (i.e., women-only therapy groups versus mixed groups): offers a safe environment to discuss topics that might not be discussed in a mixed group; tends to be more supportive and less confrontational, focusing on women's strengths and empowerment; and allows women to focus on their own needs away from concerns of social approval and welfare of others (Vandiver, 2007).

Protective Factors

Protective factors in health are characteristics that reduce the likelihood of disease, injury, or disability. They can include such things as behavior, environmental factors, and internal characteristics.

Why do some people, when faced with significant challenges, seem to thrive while others suffer physically and mentally? A longitudinal study looking at this question found that those who thrived maintained three key attitudes that helped them turn adversity into an advantage: commitment, control and challenge attitudes. The commitment attitude led them to strive to be involved in ongoing events, rather than feeling isolated. The control attitude led them to struggle and try to influence outcomes, rather than lapse into passivity and powerlessness. The challenge attitude led them to view stress changes, whether positive or negative, as opportunities for new learning (Maddi, 2002).

Participants in the Surgeon General's Workshop on Women's Mental Health brainstormed to create a list of specific protective factors for women's mental health. Among those identified were one or more significant relationships; good nutrition; social supports; community connections; supportive relationships; strength-based competencies, self-efficacy; empowerment; knowledge and education on mental health issues; healthy lifestyles; adequate health care access and quality; ownership and informed choices regarding a woman's own body; spirituality; cultural values and traditions; respect for diversity, including sexual orientation and women who are not mothers; awareness and acceptance of trauma histories; and integration of mind, body, and spirit (Surgeon General, 2005).

From this list, four general categories were identified for classifying these different protective factors:

— **Relationships and social and community supports**

— **Strength-based competencies and self-efficacy**

— **Knowledge, education, and recognition**

— **Culture, spirituality, and traditions**

The World Health Organization has identified a similar set of main factors considered highly protective for women against the development of mental problems, especially depression (WHO, 2008):

— **Having sufficient autonomy to exercise some control in response to severe events**

— **Access to some material resources that allow the possibility of making choices in the face of severe events**

— **Psychological support from family, friends, or health providers**

VI

Meeting the Challenges/ Innovative Trends

Below are some examples of innovative approaches and trends to address some of the numerous mental health challenges facing women and women's mental health care providers. While by no means exhaustive or comprehensive, these examples highlight the types of efforts currently in practice. Some aim to address a very specific narrow area of concern; others have a much broader focus.

Mental Health system Navigators for Women

A number of communities and organizations have begun to use patient navigators to help address the often very complex health care system and the vast array of information and choices that confront individuals facing major health issues. A patient navigator is a person who helps a patient move through the health care system and overcome any barriers to treatment (Dohan and Schrag, 2005). A navigator can help provide information and advice, coordinate care, and address barriers for an individual (including such things as financing, insurance, transportation, and child care).

While patient navigators have most often been seen in cancer care, the role of a navigator may be particularly beneficial in mental health care and in integration of medical and mental health care. One recent study found that providing patients who had experienced a psychiatric crisis with a care manager for primary care following the crisis was an effective way to help the patient access care (Griswold et al., 2008). In some cases, patient navigators are women who themselves have experienced a mental illness. These navigators, often called peer specialists or recovery specialists, offer support and hope and help to reduce the shame, stigma, and isolation women may feel when being treated for a mental illness.

Attention to Comorbidities

As noted previously, there is a strong connection between physical and mental health. Research has identified a number of cases where a specific disease puts a person at greater risk of mental disorder and where having a specific mental disorder puts a person at greater risk of a particular physical condition (Harter et al., 2007). For example, heart disease patients with depression have a higher risk of mortality, which may in part be the result of reduced adherence to medical treatment and less physical activity compared with those without depression (Casey et al., 2008; Whooley et al., 2008). Depressive symptoms in adolescence increase the risk of obesity later in life (Liem et al., 2008). Individuals with PTSD have a greater risk of chronic medical conditions, and multiple trauma exposure has a cumulative effect on physical health (Sledjeski, Speisman, and Kierker 341-49). A study looking at individuals with both obesity and depression concluded that treating the depression first could "potentially boost the impact on both the mental and physical health outcomes" (Schneider et al., 2008).

While both men and women with mental illness face greater medical problems than those without mental illness, research has identified a number of unique experiences, risks, and needs among women that can influence the choice of treatment approaches. For example, women with severe and persistent mental illness

have "increased rates of multiple or co-morbid medical problems due to history of trauma (e.g., sexual abuse, domestic violence), barriers to treatment of physical illness (e.g., poverty, lack of insurance, misdiagnosis, or under diagnosis), lifestyle choices (e.g., high smoking prevalence and substance misuse), effects of medications (e.g., obesity and diabetes mellitus related to certain psychiatric medications), and consequences of the illness itself (e.g., neglect of personal care)" (Vandiver, 2007).

Workplace Support Groups/Programs for Caregiver Stress

Caring for a loved one can be difficult and stressful, requiring the caregiver to face numerous financial, emotional, and physical challenges. Meeting these demands while also meeting demands in the workplace increases the potential stress burden. While some support services are available through local government agencies, service organizations, or faith-based organizations, employers are also implementing workplace support programs as one way to mitigate the impact of caregiving on workers. Up to 30% of employees have elder care responsibilities, and approximately two-thirds of caregivers ages 51 to 64 work, most full-time (AARP, 2008).

The stress and demands on the caregiver can cost the employer through such things as diminished productivity, absenteeism, poor morale, health problems related to stress, and mistakes or accidents. Many employers have established programs or policies to help support employees who are caregivers. According to AARP, 25% of all businesses offer elder care benefits such as resource materials and referral services, unpaid leaves of absence, dependent care flexible spending accounts, and workplace support groups.

Trauma-informed Care

Trauma-informed mental health care is service that is "based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization" (SAMHSA, 2008). Trauma-informed care is generally designed to address the consequences of trauma in the individual, to recognize the individual's need to be respected and to be hopeful in recovery, and to work collaboratively with the individual, family and friends, and other human service agencies.

A five-year federally funded study looked at women with co-occurring substance abuse and mental health disorders who had experienced trauma and the effects of trauma-specific service intervention models integrating trauma, mental health, and substance abuse issues. The study found that the integrated interventions were cost-effective and had significantly positive outcomes for the women and their children (Jennings, 2004).

Telepsychiatry

Telepsychiatry—the use of telephone, e-mail, videoconferencing, and so forth to provide services—is increasingly being used to provide mental health services to people who would otherwise not have access (e.g., rural, remote, or underserved areas; homebound people; people with child care or elder care responsibilities).

Telepsychiatry can connect patients with psychiatrists and other health care professionals through the use of video cameras and microphones. Services that are provided via telepsychiatry include diagnosis and assessment, medication management, and individual and group therapy. Telepsychiatry also provides an opportunity for consultation between psychiatrists and other health care providers. While there is limited data specifically on outcomes, a review of hundreds of studies of telepsychiatry concluded that there was no difference in accuracy or satisfaction between telepsychiatry and face-to-face care (Hyler, Gangure, and Batchelder, 2005).

Recovery Orientation

The recent focus in mental health treatment on recovery reframes treatment around the goals and desired outcomes as expressed by the woman in treatment. A *National Consensus Statement on Mental Health Recovery* developed by SAMHSA in 2006 emphasizes that recovery goes beyond symptom reduction:

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (SAMHSA, 2006).

Recovery focuses on each woman's strengths, building treatment around desired life outcomes and not simply symptom reduction. Recovery actively engages each woman in tracking her symptoms, identifying her triggers, and managing her wellness.

Summary/Recommendations

VII

Women's mental health is essential to overall health, and mental illness takes a tremendous toll. In any given year, 20% of the adult US population has a mental disorder, and mental disorders are the leading cause of disability in the United States for people ages 15 to 44. Overall rates of psychiatric disorder are almost identical for men and women, but striking gender differences are found in the patterns of mental illness. Mental disorders such as depressive disorders, eating disorders, PTSD, and anxiety/panic disorders affect women significantly more than men. In addition, there are numerous particular areas of concern for racially, ethnically, and linguistically diverse women, and special populations of women such as teen girls, caregivers, elderly women, rural women, women with coexisting medical conditions, and others.

Mental health in women must not only be safeguarded, but also promoted through public education (increasing knowledge and decreasing stigma), increased inclusion of racially diverse women in research, and the empowerment of women in society. Promoting mental health in women and increasing access to treatment are possible only through collaboration of health professionals from various disciplines, policy makers, advocates, and others. An increased focus on wellness and prevention will also be key. Because primary care is the major point of entry into mental health care, one of the keys to improving women's mental health care is improving access through primary care settings (family physicians, internists, obstetricians and gynecologists, pediatricians).

It has been observed that women prefer a helping context that fundamentally differs from those preferred by men. This suggests that methods of addressing the mental health demands of women need to be gender sensitive. When taking into consideration the many special populations of women with distinct needs, it seems also imperative that outreach and services take into consideration what has been learned about women in these special populations.

Mental disorders must be viewed like other chronic medical conditions and are highly treatable. This message needs to be further understood to combat stigma and encourage more people to seek the treatment they need. In addition, there is a need for broader understanding of the variety of treatments available (Surgeon General, 2005).

Recommendations

The participants in the initiative identified three broad areas of focus to improve women's mental health.

Improve access to quality care for all women. Overall, the focus should be on "equal access to quality services," broadly defining services to include prevention, treatment, coverage (parity), research, education, access, environmental issues, and integration encompassing differences in racial membership, ethnicity, language, developmental stage, education, gender, and geographic circumstances. A key aspect of access is coordination of care (through such things as improved mental health care in primary care settings, establishment of centers of women's health, use of peer coaches, and use of the medical home concept—continual care that is managed by a single personal physician).

Increase knowledge and empower women. Increase knowledge and skills related to women's mental health issues among both the public and professionals through such things as use of decision-making tools (available through the Internet, community organizations, women's magazines, professional caregivers, etc.) and multidisciplinary training. Focus on empowering consumers (women and girls) and increasing public awareness, and in particular women's self-awareness of mental health issues, needs, warning signs, and so forth.

Focus on prevention and mental *health* (rather than mental *illness*). Focus on mental health (e.g., take care of yourself) with an emphasis on positive mental health messages and promoting overall health: body, mind, and spirit. Increase focus on prevention and protective factors, for example, suicide prevention through efforts of peer support and trauma-informed care through schools, Internet, media, and community support.

Conclusion

The Women's Mental Health Leadership Summit was convened to provide a forum for hearing views on the mental health of women from a wide variety of perspectives. The American Psychiatric Association Office of Minority and National Affairs (OMNA) and the American Psychiatric Foundation (APF) are pleased to present this summation of women's mental health issues as a next step in the ongoing effort.

This report identifies some of the key mental health issues, concerns, and problems facing women of diverse backgrounds and circumstances as well as some innovative trends and programs in women's mental health care. The challenge now is to move forward in more broadly addressing the issues. It is our hope that this report will help to enlighten the reader and inspire further collaboration and advocacy to improve women's mental health across the U.S.

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Appendix

American Psychiatric Association & American Psychiatric Foundation
Women's Mental Health Roundtable and Leadership Summit

December 10–11, 2007

Participating Organizations

American Academy of Family Physicians
www.aafp.org

American College Health Association,
Coalition on National Health Objectives
www.acha.org

American Psychiatric Association
www.psych.org

American Psychiatric Foundation
www.psychfoundation.org

American Psychiatric Nurses Association
www.apna.org

American Public Health Assosciation
www.apha.org

Association for Behavioral Health and Wellness
www.aphw.org

Cobb National Medical Association Health Institute
http://cobb.nmanet.org

Department of Health and Human Services

— Health Resources and Services Administration
www.hrsa.gov

— Office on Women's Health
www.womenshealth.gov/owh

— Substance Abuse and Mental Health Services
www.samhsa.gov

Depression and Bipolar Support Alliance
www.dbsalliance.org

Mental Health America
www.nmha.org

National Association of Social Workers
www.nasw.org

National Council of La Raza —
Institute for Hispanic Health
www.nclr.org

National Latino Behavioral Health Organization
www.nlbha.org

National Medical Association
http://www.nmanet.org

OWL The Voice of Midlife and Older Women
www.owl-national.org

Partnership for Workplace Mental Health
http://www.workplacementalhealth.org

Physicians for Reproductive Choice and Health
www.prch.org

The Cave Institute
www.thecaveinstitute.com

University Health Network,
Women's Mental Health Program
http://www.uhn.on.ca

University of Alabama Birmingham,
School of Nursing
http://main.uab.edu/Sites/nursing

University of Florida, Department of Psychiatry
http://www.psychiatry.ufl.edu

University of Illinois at Chicago,
Department of Psychiatry
http://www.psych.uic.edu

Women's Policy, Inc.
www.womenspolicy.org

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