Selected Research and Commentary

about Women’s Mental Health

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**Prevalence of Mental Conditions**

Though a range of issues concerning research methods contribute to widely differing results in many instances, investigations have generated fairly consistent findings about the prevalence of mental health conditions among women and men, and the social conditions which contribute to these trends.

*The Prevalence of Mental Health Conditions*

Australian and international studies establish that a markedly higher proportion of women than of men experience mental health conditions (Abel and Newbigging, undated). The United Kingdom Mental Health Foundation, for example, found that approximately 19% of women and 6% of men had current mental health problems (UNISON, 2017).

The 2020/22 Australian National Study of Mental Health and Wellbeing determined that 25% of women and 18% of men had experienced such problems in the previous 12 months (ABS, 2022D), while in the 2021 Census 11.5% of Victorian women and 7.4% of men, stated that they had a long-term mental condition.

*The Prevalence of Depression and Anxiety*

More particularly, investigations confirm a high prevalence of depression and anxiety among women (Homewood Health, 2023; Marrow, undated; Ottin et al, 2022; Gender and Health, 2002; Fisher and Hailes, 2017; WHO, 2000, 2017).

The US National Epidemiologic Survey on Alcohol and Related Conditions determined that, at some time in their lives, 23% of women and 13% of men had experienced depressive conditions, and 5.8% of women and 3.1% of men had had anxiety conditions (Eaton et al, 2012). A similar disparity was recorded by the US National Survey on Drug Use and Health which found that 7.9% of females and 3.2% of males reported that they had experienced anxiety conditions, and 9.3% of females and 5.4% of males, had experienced mood conditions, during the previous 12 months (Karg, 2014).

Local trends are consistent with these findings. The Australian 2020-22 National Study of Mental Health and Wellbeing recorded that 7.5% of 16-85 year-old survey participants stated that they had experienced an affective - or mood – condition in the previous 12 months, including 8.5% of females and 6.2% of males. Anxiety disorders in the previous 12 months were reported by 21.1% of females and 12.4% of males (ABS, 2022D).

The prevalence of mood conditions declined with age among women, from 19% among 16-24 year-olds, to less than 1% among those aged 75 years or more – reflecting a decline with age reported elsewhere (Kiely et al, 2019). The prevalence of mood disorders among males was more stable across the lifespan.

The prevalence of anxiety disorders by age and sex: Australia, 2021/22

The experience of anxiety conditions within the previous 12 months was recorded by 21% of female survey participants and 12% of males.

The prevalence of anxiety conditions by age and sex: Australia, 2021/22

Anxiety was most widespread among 16-24 year-old females and males, at 41% and 21% respectively, and receded with age.

These disparities in the prevalence of mental conditions are echoed by the results of an Australian Institute of Health and Welfare investigation which demonstrated that the contribution of depression and anxiety to disability adjusted life years (DALYs) - a measure which blends reduced quality of life and life span - was higher in women than among men, with anxiety disorders registering the fourth highest contribution to DALYs among women, and depression the sixth highest (2021).

Rosenfield and Smith(2012) conclude that the higher prevalence of depression mong women means that women more often "...live with feelings of sadness and loss, negative self-concept, and feelings of guilt, self-reproach and self-blame…loss of energy, motivation and interest in life", than men.

*The Prevalence of Other Mental Conditions*

Further research has established that eating and panic disorders, phobias, suicide attempts, borderline personality disorders, sleep problems, fatigue and post-traumatic stress are more widespread among women than men (Marrow, undated; Toribiio-Caballero et al, 2022; Ottin et al, 2022; Women’s Mental Health Alliance, 2021).

The American Psychiatric Association for example, reported that women are approximately twice as likely to have experienced panic disorders, phobias, and post-traumatic stress than men, and three times more likely to have obsessive-compulsive disorders (2017).

In the 2007 National Survey of Mental Health and Wellbeing (ABS, 2008), post-traumatic stress disorder, depression and social phobias were most common among women, while men predominated among those who had experienced substance disorders during their lifetimes. Similar findings were generated by the 2020-22 Australian National Study of Mental Health and Wellbeing, which determined that panic disorder, agoraphobia, social phobia, anxiety and post-traumatic stress disorder were approximately twice as prevalent among women as men (ABS, 2022D). (diagram, right).

Per cent of Persons who had Experienced Mental Health Disorders during the previous 12 months, by detailed category and sex: Australia, 2020/22

*Males and Mental Conditions*

An outline of the prevalence of mental health conditions among males lends perspective to the present review of women’s experiences.

In contrast to the higher prevalence of depression, anxiety, post-traumatic stress disorder and other conditions among women, elevated rates of impulse control issues, substance use problems, suicide and antisocial behaviour have been consistently documented among males (Moller-Leimkuhler, 2003; Sullivan et al, 2020; American Psychiatric Association, 2017; Gender and Health, 2002; Karg, 2014).

The US National Epidemiologic Survey on Alcohol and Related Conditions recorded lifetime antisocial personality disorder among 5.5% of men and 1.9% of women, and alcohol dependence among 17.4% of men and 8% of women (Eaton et al, 2012). Similarly, the Australian 2020-22 National Study of Mental Health and Wellbeing found that among 16-85 year-olds, substance use disorders had been experienced by 4.4% of men and 2.3% of women (ABS, 2022D).

Suicide rates are also higher among men than women (Ottin et al, 2022; The Women’s Health Council, undated). In Australia, rates among males stood at 19.6 per 100,000 in 2020 - over three times the corresponding rate of 5.1 per 100,000 for females. Among males, suicide rates are highest among middle and late older age (ABS, 2020A).

Suicide Rate by Age and Sex, Australia, 2020

A variety of explanations are advanced for the preponderance of males among suicides, including a lesser fear of death and sensitivity to pain; a higher prevalence of impulsive and aggressive tendencies; an unwillingness to acknowledge or communicate their own distresses; limited social connections and access to support; a reluctance to seek help; lack of awareness of, or confidence in, support services; and a propensity to select more lethal methods of suicide (Poynton-Smith, undated; Goldney et al, 2002; Howerton, et al, 2007; Witte et al, 2002; Denney et all, 2009; Galdas et al, 2005; Hines et al 2014; Bruffaerts et al, 2011; Joiner, 2005; Schuacher, 2019; Carley 2018; Comstock, 2016).

*Sex Differences in the Presentations of Mental Conditions*

Some investigators point to a fundamental difference in the responses of females and males to emotional distresses, which may explain some of the differences in the prevalence of mental health problems.

Women, they contend, are more inclined to direct negative or problematic emotions inwardly, ‘toward the self’ as Rosenfield and Smith (2012) express it, often resulting in withdrawal, depression and anxiety. It is postulated that men, on the other hand - and boys (Van Droogenbroeck et al, 2018), tend to express their emotional distresses externally, resulting in impulsive, aggressive and destructive behaviour - to themselves and others - as well as substance use problems (Eaton et al, 2012; Homewood Health, 2023; Gender and Health, 2002; Ottin et al, 2022; Rosenfield and Smith, 2012).

Some writers propose that society considers fear, anxiety and sadness, and speaking about personal feelings acceptable in women, but not in men, among whom it is more approving of aggression and anger, with The Women’s Health Council (undated) characterising this distinction as "...a gendered expression of a shared underlying emotional difficulty".

*Men and Social Roles and Expectations*

A relevant observation is offered by commentators who maintain that social norms and expectations impose an obligation upon many boys and men to display independence and power, subdue their feelings, stifle emotional expression and avoid displays of vulnerability, thereby promoting assertiveness, stoicism, emotional inexpressiveness, and deterring many from seeking help with personal distresses (Moller-Leimkuhler, 2003; Carley, 2018; Comstock, 2016; Behavioural Health and Rape Crisis Centre, 2019; Rosenfield and Smith, 2012). For example, research shows that men tend to cry less often than women (Patterson, 2020) – a pattern which emerges in pubescence, pointing to a social foundation, rather than a biological origin, of this difference (Sharman et al, 2019).

Investigators postulate that such conditions may predispose some men to depression, substance abuse and antisocial behaviour (Moller-Leimkuhler, 2003; Rosenfield and Smith, 2012). Summarising extensive research on this subject, Our Watch (2019) explains that those who adhere to traditional beliefs about what it means to be a man tend to experience more adverse health outcomes, including high rates of suicide, harmful use of alcohol and other drugs; difficulty dealing with emotional distress; limited support and social networks; and risk-taking behaviours.

**Conditions Affecting Women and their Mental Health**

*Biological Factors*

A number of health conditions that are particular to, or more common among, women, may contribute to mental health issues. These include post-natal depression, effecting 8-15% of new mothers (UNISON, 2017), dementia, about twice as prevalent among women as men owing to their greater longevity (Marrow, undated), and conditions such as endometriosis and menopause, which may detract from mental health and wellbeing (American Psychiatric Association, 2022; Laganà et al, 2017; Jessa, 2020; Stein et al, 2023).

However, although genetic factors appear to contribute to mental illness, research points to the conclusion that their prevalence is similar among females and males, with the implication that such heritable conditions may not explain sex differences in the prevalence of mental health conditions (Piccinelli and Wilkinston, 2018).

Instead, evidence confirms national differences in the prevalence of various mental health disorders - with lesser gender disparities in countries, such as Scandinavian nations, where women are accorded more equal status and opportunities to men (Velde et al, 2021; Gong and Wong, 2018; Marrow, undated).

Some investigators therefore express the view that, while biological explanations do not offer a sufficient explanation for disparities between women and men in the prevalence of mental disorders, cultural and societal conditions exert the more decisive influence (Velde et al, 2021; Gong and Wong, 2018; Fisher and Hailes, 2017; Piccinelli and Wilkinson, 2018). It is therefore to these circumstances that many look for a clearer understanding of the prevalence and causes of mental health problems among women.

*Social Conditions and the Prevalence of Mental Conditions among Women*

Many writers hold that restrictions which social norms and expectations set upon the opportunities and development of women, as well as lack of respect accorded to women, and their experience of discrimination, exploitation and violence, inflicts elevated levels of stress upon women, resulting in a higher prevalence of mental health problems - a circumstance which The Women’s Health Council (undated) characterises as "…the social legacy of being a woman".

Among the social conditions which may contribute to personal stress and the onset of depression, anxiety or other mental health concerns among women, are their confinement within rigid, traditional roles; the high workload stemming from often multiple responsibilities; lack of acknowledgment of, or respect for, their work; lesser educational and employment opportunities; lower incomes and financial dependence; the social pressures of striving to attain a feminine ideal; accompanying concerns about physical appearance; a lesser status and respect accorded to women; and their exposure to violence and abuse (Eaton et al, 2012; Riecher-Rossler, 2016; The Women’s Health Council, undated; WHO, 2004). These issues form the subject of succeeding sections.

*The Impacts of Caring and other Unpaid Work*

Such social conditions frequently set limits to the power, resources and social or economic opportunities that are extended to women (World Health Organisation, 2017; Victorian Women’s Health Services, undated). These include restrictive, traditional roles (Reicher-Rossler, 2017) and they are associated with a higher prevalence of mental health concerns (Van Droogenbroeck et al, 2018). In addition, it is observed that cooking, cleaning and other housekeeping – for many, an arduous and thankless routine steeped in repetition and monotony, and accorded low status and value - may also contribute to mental stress and ill-health (Cannuscio, 2002).

On average, women perform about twice as much unpaid work around the home, and unpaid care for children, as men. The 2021 Census recorded that Victorian women aged 20-79 years performed an average of 12.4 hours of unpaid work at home each week, compared with 6.8 hours among men. Among people in full-time paid work, this difference persisted, with women performing an average of 9.7 hours per week in unpaid domestic work, in contrast to 6.4 hours among men. Similarly, unpaid childcare to their own or others’ children was provided by 51% of Victorian women aged over 15, and 39% of males.

Pandemics and lockdowns, it appears, afford little relief: Kaplan (2021) recounts the findings of a survey of housewives during the COVID quarantine, which found that the women remained largely responsible for all housework as they were before the pandemic, despite the fact that all family members were at home – a circumstance which contributed to elevated levels of stress and loneliness among many.

It is reported that such caring and other domestic responsibilities, often coupled with obligations relating to paid employment, may contribute to mental stress among women (Victorian Women’s Health Services, undated; American Psychiatric Association, 2017), particularly among those with young children, when caring responsibilities may be most intense, or women who are obliged to provide a high level of care for a spouse or other family member (The Women’s Health Council, undated; Leupp, 2017). Cannuscio (2002) cites a US study which concluded that women who care for spouses for a substantial number of hours per week were more likely to experience mental health problems than non-caregivers. Indeed, the 2021 Census found that 7.7% of Victorian women who performed unpaid work at home were experiencing a long-term mental health condition, compared with 15% of those doing 30 or more hours of unpaid work per week.

*The Burden of Multiple Roles*

For many women, the often-onerous (Piccinelli and Wilkinston, 2018; Rosenfield and Smith, 2012; The Women’s Health Council, undated; Durak et al, 2003; Kaplan, 2021) domestic roles of caregiving and housekeeping are coupled with paid employment - frequently in insecure, tedious and low-paid work - representing the burden of two jobs, and contributing to stress (WHO, 2000; Piccinelli and Wilkinston, 2018). One survey of Australian women found that among those aged 20-28 in particular, one of the principal sources of stress was the challenge of balancing career and homework (Nielsen Research, 2022). Accordingly, The Women’s Health Council (undated) characterises the roles of many women in reproduction, caring and paid work as a 'triple burden'.

Such multiple roles may be especially arduous for women with younger children - echoing observations made in an earlier section. In their interpretation of the findings of the US National Longitudinal Survey of Youth, which traced the experiences of respondents though life, Leupp (2017) concluded that employment of women with children detracted from their mental health when the children were younger but was associated with improved mental health as the children became older.

*Lower Status accorded to Women and their Work*

The low status and disrespect accorded to some women, and the discrimination inflicted upon many, is the subject of extensive commentary (Women’s Mental Health Alliance, 2021; WHO, 2000, 2004; Victorian Women’s Health Services, undated), with the World Health Organisation (1998) noting that women's mental health, particularly depression, is inseparably linked to women's lower status in society – adding, incidentally, that it could not identify any society that treats women as the equal of men.

It is also widely observed that the tasks of housekeeping, cleaning, cooking and caring for children and other relatives is often accorded little value (Piccinelli and Wilkinston, 2018; Fisher and Hailes, 2017), with some submitting that the higher prevalence of depression among women is partly a result of lack of acknowledgement for their work (WHO, 2004).

Rosenfield and Smith (2012) offer the explanation that economic resources generated by paid employment are highly valued in society, whereas providing care and emotional support are held to be of less value and largely confined to the family, with the result that economic resources are more highly regarded than the personal benefits which many women supply to their families.

*Social Isolation*

Social isolation is identified as a further consequence for many women engaged in caring and housework - particularly those who are providing high levels of care for a family member, or who lack personal support or social outlets – with consequences which may include an increased prospect of personal distress and mental health concerns (Fisher and Hailes, 2017; Durak et al, 2003).

*Guilt, Self-worth and the Caring Ideal*

Among some women engaged in work within the home, paid employment may detract from the time and resources they are able to devote to such efforts, thereby fostering a sense of guilt and diminished self-worth (Piccinelli and Wilkinston, 2018), especially those who rely upon such work as a foundation for their identity and self-esteem. Research conducted by Barelli (2016) found high levels of guilt among mothers, stemming from their concerns that time required for their paid job detracted from their role in caring for their children. An interview study conducted by Liss et al (2013) among mothers of children aged over five years, found that “…women who failed to live up to their sense of the ideal mother…” experienced higher levels of guilt and shame than others.” - conditions which Rizzo et al (2012) observe, are associated with depression. Other investigations have also documented guilt related to conflict between the roles of parenthood and paid employment (Shaw and Burns, 1993; Korabik, 2014).

Fisher and Hailes (2017) contend that "…women's propensity to worry reflects entrenched patterns of socialization in which girls and women are confined to passive roles and are given fewer developmental opportunities to develop mastery and experience agency than their male counterparts."

In a related observation, some writers maintain that the higher level of engagement of women than men in caring roles, coupled with their socialisation to be nurturing, considerate of the views and feelings of others, privileging "...the needs of others above the self" (Rosenfield and Smith, 2012), renders them more susceptible to interpersonal discord or conflict (The Women’s Health Council, undated), thereby contributing to a higher prevalence of depression.

Piccinelli and Wilkinston (2018) recount the results of an investigation which determined that the greater frequency of episodes of personal distress among women than men was largely confined to incidents relating to children, housing or reproductive issues. The author concluded that disparities in the prevalence of mental health issues may be related, in part, to differences in the social roles of women and men.

Others hold that compliant responses to social confrontations or psychological adversity may predispose women to mental health problems (Women’s Mental Health Alliance, 2021). A study reported by Toribiio-Caballero et al (2022) found that women who ranked care for children and congeniality highest among their personal priorities were more likely to be receiving treatment for mental health conditions. The authors concluded that the burden of mental health upon women would be eased if women’s roles were more pliable and "...less constricting of people's potential, resulting in improved health."

*Lack of Autonomy and Control*

A related consideration is the lack of autonomy afforded to some women, with their confinement in traditional roles accompanied by limited status, resources and power, thereby depriving many of the means to wield influence upon matters that are important to them or conducive to their health and wellbeing (Victorian Women’s Health Services, undated; Rosenfield and Smith, 2012). Accordingly, some maintain that higher rates of depression among women may be predisposed by "frequent exposure to uncontrollable life events", such as ill-health, acquiring paid work and enduring unfavorable workplace environments (Gender and Health, 2002).

One commentator concludes that as females reach adolescence, they become aware of social norms which prescribe certain patterns of behaviour for women, causing them to "lose their voice and confidence", and increasing their susceptibility to depression (Casey, 2002).

*Body-image and Self-esteem*

Research shows that concerns about body image and eating disorders are prevalent among young people - particularly young women (Fisher and Hailes, 2017; Van Droogenbroeck et al, 2018; Carlat and Cmargo, 1997) - and often coupled with lower self-esteem (Gender and Health, 2002) and depression (Homewood Health, 2023; Riecher-Rossler, 2016; Nielsen Research, 2022).

In an Australian study of 1,600 secondary students, researchers documented a markedly higher prevalence of eating disorders among females, at 22 person years per 1,000 students, compared with 6 person years per 1,000 among males, maintaining that the difference was related to the more widespread practice of dieting among the female students (Paton et al, 1999). Carlat and Cmargo (1997) also concluded that eating disorders were most prevalent among females, who accounted for at least 9 in 10 of those with bulimia and anorexia, in their research.

Further inquiries disclose an association between exposure to idealized images of women and men in the media, and both a desire to achieve high standards of perceived attractiveness among girls and women, and dissatisfaction with their own appearance (Mills et al, 2007; Richins, 1991). It is scarcely surprising then, that depictions of slim body types in the TV, magazines and social media have accentuated the prevalence of such eating disorders (Becker, 2004; Meier, 2013; Vigo, 2019). For example, in a US study of 5th to 12th grade pupils, those who most frequently read magazines were 2-3 times more likely than others, to be dieting to lose weight due to the influence of the magazine content (Field et al, 1999). A further investigation found that who were presented with thin, idealized media images formed more unfavorable impressions of their own bodies, than those who viewed images of average- or plus-sized women (Groesz and Murnen, 2001).

As Vigo (2019) declares: “We need to demand that media messages directed to girls and women [neither push them] toward marriage or the functional role of a princess. What if we dare imagine a world where neither is a desired option?”

*Limited Employment Opportunities and Adverse Employment Conditions*

International research has established that the fewer employment opportunities available to women contributes to their personal stress and fuels depression (WHO, 2004). Australian trends are consistent with this proposition: the 2021 Census found that long-term mental health conditions were experienced by 14.3% of Victorians who did not hold paid employment and 9.1% of those in paid work.

Notably though, the gap between women’s and men’s participation in paid work has contracted in recent decades. In August 2023, 69.4% of Victorian males and 61.2% of females, aged 15 years or more, were in paid employment, a difference of 8.2%, compared with 25% in 1978 (ABS, 2023A).

However, it is reported that limited job security, low pay, lack of recognition and status at work are still more widely experienced by women than men, and thereby contribute to their higher prevalence of depression and anxiety (Gender and Health, 2002; Benach et al, 2020). Autonomy in the workplace is related consideration, with Shrier (2002) pointing to "the greater likelihood of women's working in jobs that have less autonomy and control over hours and work content" as a cause of stress.

*Workplace Sexual Harassment*

A related subject is workplace sexual harassment. The Sex Discrimination Act 1984 defines sexual harassment as any unwelcome sexual advance, request for sexual favors, or conduct of a sexual nature in relation to the person harassed, in circumstances where a reasonable person would have anticipated the possibility that the person harassed would be offended, humiliated or intimidated.

In 2018 an Australian Human Rights Commission survey of 10,000 Australians aged over 15, found that 23% of females in paid employment, and 16% of males, had been sexually harassed at the workplace in the previous 12 months, while 39% of females and 26% of male survey participants had experienced such harassment in the previous five years (diagram)

Per cent of survey respondents who had experienced sexual harassment in the previous five years: Australia, 2018

While about two-fifths (41%) of those who were harassed felt the incident had no impact upon them, others reported stress, reduced self-esteem, employment impacts and deterioration in relationships.

Similar findings emerged from a 2020 survey of local government staff commissioned by the Victorian Auditor General’s Office (2020), with 49% of women and 33% of men who had been sexually harassed reporting adverse effects upon their wellbeing and employment.

*Lower Incomes and Financial Insecurity*

Women are in receipt of lower incomes than men (Victorian Government, 2016), with median individual incomes in Victoria among 15-64 year-olds 3% higher among males than females in hourly rates of pay, 13% higher among people in full-time work, 30% higher among those in paid work, and 55% higher among males than females overall, at the time of the 2021 Census (ABS, 2022C). As a consequence, superannuation levels at retirement tend to be lower among women than men. In Australia, median superannuation held by people aged 60-64 in 2020, stood at $204,000 among men and $147,000 among women – a 28% difference (Kitchen et al, 2021).

Of sole parents, among whom women predominate, such disadvantages may be more pronounced. In 2021, over four-fifths (81%) of sole parents in Victoria were females, who received lower median weekly incomes ($1,324 compared with $1,662), were more likely to be without paid employment (45%[[1]](#footnote-1) compared with 36%), and less often owned their home (62% compared with 57%), than their male counterparts.

Consequences of lower incomes for some women include financial dependence, poverty and insecure and inferior housing - all widely recognised as risk factors for stress and mental conditions (American Psychiatric Association, 2017; Abel and Newbigging, undated; Victorian Women’s Health Services, undated; Velde et al, 2021; WHO, 2000) – a conclusion substantiated by available research.

Kosidu et al (2011) for example, report findings of a population survey which determined that people in receipt of lower incomes were more likely to experience depression than those on higher income levels. In an analysis of the findings of the National Study of Mental Health and Wellbeing 2020/21, Isaacs et al (2018) disclosed that 5.2% of the most socioeconomically advantaged fifth (or quintile) of the Australian population, and 25% of the least advantaged quintile of Australians, had ‘high’ or ‘very high’ levels of psychological distress. In Victoria, the 2021 Census found that 17% of women on lower incomes (<$650 pw), and 12% of those on higher incomes (>$1,250 pw), were experiencing a long-term mental illness.

Relevantly, Brown and Harris (1978) conclude that the lower mental health of women living in socioeconomic disadvantage is largely due to the impact of such conditions upon their lives, rather than to women with prior mental health problems experiencing dwindling incomes and receding employment opportunities.

As one commentator tells it, conditions of inequality of opportunity and poverty, related to access to employment, income levels and other living conditions, may generate stresses which "…can lead women to feel that they have lost control and a sense of direction over their lives" (Homewood Health, 2023).

Moreover, financial dependence compels many women to remain in violent or abusive relationships (Abel and Newbigging, undated; The Women’s Health Council, undated), a subject addressed below.

*Violence and Women’s Mental Health*

The Prevalence of the Experience of Violence among Women

The 2016 Personal Safety Survey investigated the experience of violence, including intimate partner violence and child abuse, among adult women and men in Australia. The survey found that 37% of women had experienced violence (including threats of assault) during their lifetimes - including sexual violence (18% of women, compared with 5% of men) and physical violence (31% of women).

In response to inquiries about intimate partner abuse, 22% of women and 7% of men, stated that they had been assaulted by a partner since age 15. Women were three times as likely to have been physically assaulted by partner as men, and nearly eight times more likely to have been sexually assaulted.

And approximately one in six (16%) females and one in ten (11%) males stated that they were abused before the age of 15. Nine per cent of females had been physically abused and 11% sexually abused. By contrast, 8% of males had been physically abused in childhood and 5% sexually abused (ABS, 2017).

In addition to the higher prevalence of the experience of intimate partner violence, it is reported that the nature and impact of such crimes upon women and men may differ, with violence against women more often accompanied by intimidation, and an enduring or repetitive pattern of control, than violence experienced by men (ANROWS, 2020). Indeed, Australian research conducted by National Crime Prevention found that 24% of women and 5% of men reported that they had experienced fear or physical harm as a consequence of physical aggression inflicted by an intimate partner (Flood and Fergus, undated).

Impacts of Violence Upon the Mental Health of Women

The high rate of interpersonal violence experienced by women, including sexual violence, intimate partner violence and child abuse, is widely recognised as a major contributor to mental health problems among women throughout the world (Riecher-Fossler, 2017; Abel and Newbigging, undated; Gender and Health, 2002; Piccinelli and Wilkinston, 2018; ANROWS, 2020, 2022; Nielsen Research, 2022; Women’s Health Victoria, 2019), with effects that include depression, anxiety, post-traumatic stress, panica attacks, fears and phobias, substance use problems and suicidal behaviour (Riecher-Fossler, 2017; Braaf and Myering, undated; Lukaschek et al, 2013; Oram et al, 2016). The Women’s Health Council adds that, aside from its psychological impacts, such violence may predispose to unemployment and lower incomes among women, thereby exposing them to conditions which further exacerbate mental health problems.

ANROWS (2020) cites The World Health Organisation’s Multi-country Study of Domestic Violence and Women's Health, which found that women who had been subjected to intimate partner violence were two to three times more likely to experience suicidal thoughts or engage in suicidal behaviour (Cited by ANROWS, 2020). Similarly, a US study determined that 63% of women who had experienced rape, physical violence or stalking, reported at least one symptom of post-traumatic stress (Black et al, 2011). Rees et al (2011) recount evidence which confirms a close association between the experience of violence among women within the previous five years, and the first onset of mental disorder, underlining the causal role of violence in the origin of such conditions.

Australian research also establishes a clear relationship between the experience of violence and subsequent mental health problems. Inquiries reported by Rees et al (2011), featuring a sample of 1,218 Australian women who had experienced partner violence, rape or other sexual violence, recorded an elevated prevalence of lifetime mental health concerns, including 77% for anxiety disorder, 52% mood disorders, 47% substance abuse, 56% post-traumatic stress disorder and 35% who had attempted suicide. Another Australian study, of approximately 60 women who had experienced intimate partner violence, determined that just over half (52%) had been diagnosed with mental illness - 43% during the period when violence was being perpetrated and 44% subsequently, after leaving their partner (ANROWS, 2020).

Other investigators add that more severe and lasting sexual abuse of girls is associated with the higher prevalence of mental health issues (Astbury and de Mello, 2000; Gender and Health, 2002).

Conversely, a further investigation, of 1,257 Australian women attending general practitioners, found that those exhibiting depression were 5.8 times more likely to have experienced physical, emotional or sexual violence than those who were not depressed (Hegarty et al, 2004). Similarly, the experience of violence and abuse is widely reported among women who are homeless, incarcerated or who are engaged in prostitution (Henderson, 1998; McDaniels-Wilson and Belknap, 2008; Saxina and Messina, 2021; Stoltz et al, 2007; The Women’s Health Council, undated).

**Intersectional Considerations**

The circumstances which influence women’s mental health, as well as the prevalence of mental health conditions, vary widely among different sections of the community. Notably, among Victorian women aged 25-44 years, the 2021 Census recorded the highest prevalence of long-term mental health conditions among those who were disabled (55%), Indigenous (34%), lone parents (24%), separated (22%), in same sex couples (22%), not employed (19%) and on low incomes - <$659 pw. (17%) and lowest among those who were married or employed (at about 10% each).

This section reviews some of the evidence and commentary about some of the differing conditions experienced by migrants and refugees, Indigenous people and members of LGBTIQ communities, as illustrations of intersectional differences in conditions affecting mental health.

*Migrant and Refugee Experiences*

Sullivan et al (2020) recount findings of Australian research which point to a higher rate of mental health problems among people from non-English speaking countries, refugees, holders of insecure humanitarian visas, and asylum-seekers. They cite the results of one study which showed that asylum-seekers and refugees in Australia with insecure visa status were approximately five time more likely to exhibit systems of depression or anxiety as those who had been granted permanent visas, and a further investigation which documented a prevalence of post-traumatic stress disorder at some time in life among 16% among migrants on humanitarian visas, compared with 12% for others.

Conditions prior to settlement such as trauma related to violence and conflict, the loss of, or separation from, family and friends, as well as torture or imprisonment, may contribute to stress, depression, anxiety and post-traumatic stress disorder (Sullivan et al, 2020).

And following settlement, a variety of adverse circumstances, including loneliness and limited sources of social support, separation from family or friends, lack of employment or unsatisfactory work, financial hardship, insecure or substandard housing, concerns for family and friends overseas, discrimination experienced personally or in the media, limited familiarity with sources of support, and the challenges of adjustment to an unfamiliar culture and language, may aggravate stress, occasioning mental health problems (Abel and Newbigging, undated; Sullivan et al, 2020; Grey, 2021; Marrow, undated; Kennedy and McDonald, 2006; Lin, 2022).

Access to employment is a further challenge for many settlers: the 2021 Census recorded 60% of Victorian women aged 25-54 who had settled in Australia within the previous five years from non-English speaking countries, held paid work, compared with 81% of those born in Australia. Evidence indicates that migrant women without paid employment tend to experience higher rates of mental disorders (Sullivan et al, 2020), a finding corroborated by the 2021 Census, which determined that 5% of employed female settlers in Victoria, and 7.8% of those without paid employment, stated that they had a mental health condition.

Moreover, for some migrant women, vulnerability to family conflict and violence may be accentuated by 'patriarchal features of their culture', as Sullivan et al (2020) observe, as well as absence of family, community or other social support; limited financial resources; precarious visa status; challenges to personal identity perceived by some partners; lack of understanding of the nature of family violence and available services; and other circumstances (Abel and Newbigging, undated; Fisher, 2013; Vaughan et al, 2015; Guruge et al, 2010; Rees and Pease, 2007).

*LGBTIQ Communities*

A succession of studies has documented higher rates of mental ill-health, including depression, anxiety and suicide, among same-sex and gender-diverse people (Victorian Agency for Health Information, 2020; McNair et al, 2004; Hill et al, 2020; Smith et al, 2014; Strauss et al, 2017).

Among lesbian women in particular, investigations have recorded a markedly higher prevalence of mental conditions than for heterosexual women, including elevated rates of stress, depression, anxiety and suicide (Alebudbud, 2023; Pöge et al, 2020), conditions which Ottin et al (2022) ascribe to discrimination and suppression of their opportunity to more freely express their gender identity and sexual orientation.

Pöge et al (2020) cite a European study which found that 14% of lesbian women had experienced substance use problems in the previous 12 months, compared with 2.9% of heterosexual women, and a US population survey which documented higher rates of marihuana use (16.7% vs. 2.6%) and addiction to alcohol (13.3% vs. 2.5%) among lesbian women, than for heterosexual women.

Similarly, in an Australian survey of 15,000 22-17 year-old women, McNair et al (2004) found that, compared with heterosexual women, those who were mainly or exclusively homosexual experienced higher rates of doctor-diagnosed depression (26.2% compared with 10.9%) or anxiety disorders (9.3% vs. 4.6%) in the previous four years, while a higher proportion of homosexual women had felt that life was not worth living during the previous week (18.4% vs. 6.5%) or had hurt or tried to kill themselves in the previous six months (17.3% vs. 2.7%).

Consistent findings emerged from the 2021 Census, in which 20.3% of Victoria women living with a same-sex partner, and 9.9% of those living with a male partner, reported a long-term mental health condition.

*Aboriginal and Torres Strait Islanders*

Elevated rates of depression and anxiety, alcohol-related problems and suicide have been documented among Aboriginal and Torres Strait Islander women (Marrow, undated). The 2021 Census recorded that 34% of Indigenous women and 15% of women in the general Victorian population, reported that they had a long-term mental health condition. The 2018/19 National Aboriginal and Torres Strait Islander Survey, conducted two years earlier, explored mental health more closely, determining that 35% of Indigenous women were experiencing ‘high/very high’ levels of psychological distress, while 25% stated that they had some kind of mental health condition, including anxiety (21%) and depression (16%).

Examining the causes of the high rate of mental health conditions among Indigenous women and men, a recent report for the Australian Institute of Health and Welfare stressed the “…intergenerational legacies of colonization: violence, trauma, abuse and social disadvantage”, including trauma inflicted by the removal of Aboriginal and Torres Strait Islander children from their parents from the late nineteenth century to 1969 (Darwin et al (2023).

As a consequence of such circumstances, a substantial proportion of women of Aboriginal or Torres Strait Islander identity face the stresses of family conflict and violence, single parenthood, unemployment and financial hardship (Abel and Newbigging, undated; Marrow, undated).

In addition, Indigenous people experience markedly higher average levels of socioeconomic disadvantage - conditions may also aggravate personal stress and predispose to mental health conditions. The 2021 Census recorded that 37% of Indigenous Victorians aged 15 or more had left school before completing year 11, compared with 21% of non-Indigenous people; 6.9% held a degree, compared with 23% of others; weekly gross personal incomes were 77% of the average among non-Indigenous population; 16% owned their homes, compared with 33% of non-Indigenous people; unemployment rates stood at 9.5% compared with 5% among the general population; and 45% of families with children were headed by one parent, compared with 23% of others.

**Addressing Women’s Mental Health: services, support and structural issues**

Commentators point up the importance of services and supports for women that are based on sound research, guided by women's views and experiences, informed by intersectional considerations, and sensitive to the broader experiences and needs of women - including their experiences of violence (Women’s Health Victoria, 2019; Nielsen Research, 2022; Kiely et al, 2019; Abel and Newbigging, undated; Marrow, undated; Women’s Mental Health Alliance, 2021; Astbury and de Mello, 2000; Gender and Health, 2002; ANROWS, 2020; Women’s Health Victoria, 2019; Reicher-Rossler, 2017).

However, emphasis is also given to the importance of preventing mental health problems by extinguishing inequality between women and men, including disparities in power, status, roles, expectations and opportunities, as well as discrimination and violence against women (Nielsen Research, 2022; Abel and Newbigging, undated; WHO, 2004), with Victorian Women’s Health Services (undated) exhorting that efforts be made to transform social conditions that predispose to mental health problems in the first place, coupled with measures to advance women's leadership and participation in civic life, and address health literacy, sexual and reproductive health.

As the World Health Organisation (2004) explains, "Empowerment is the process by which groups in a community who have been traditionally disadvantaged in ways that compromise their health can overcome these barriers and exercise all the rights that are due to them, with a view to leading a full, equal life in the best of health".

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1. Though this proportion had declined from 55% five years earlier. [↑](#footnote-ref-1)