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Rethinking the Study of Gender and Mental Health

Abstract

Gender differences in mental health status and their social determinants have drawn considerable attention in the sociology of mental health. This paper synthesizes empirical findings concerning this subject, and discusses gaps remaining in the literature. More efforts are recommended in regards to attentive examinations of (1) dynamic social contexts, (2) dissimilarities among groups in different social locations, and (3) individuals' interpretations of their distress experiences. In other words, I argue that a study of gender and mental health should not limit its investigation to gender comparison, but extend its exploration to the complexity of social and emotional lives. To achieve this goal, I propose a diamond-shaped model that highlights both structural (social and cultural) and individual (biomedical and psychological) aspects of mental health. This model suggests that sociologists focus on intersectional diversity (such as gender, class, and ethnicity), the cultural meanings of individuals' social and emotional lives shaped by their standpoints, the interplay of these structural factors, and its impact on psychological well-being.

Keywords: gender; mental health; social context, social location; culture; feminist perspective.

1. Introduction

Mental health is gendered. One of the most consistent findings in the study of mental health is that women have higher rates of depression and psychological treatment than men do (Aneshensel 1992, Caldwell, Pearson, and Chin 1987, Dohrenwend and Dohrenwend 1974, 1976, Gove 1972, 1987, Mirowsky and Ross 1986, Rosenfield 1989). The association between gender and mental health therefore has become a prominent topic not only in sociology but also in the fields of psychology, epidemiology, and public health. Sociologists have produced abundant empirical studies concerning gender differences in mental health status and their social determinants. Nevertheless, the

literature lacks a synthesis of major findings and a reflection on the current development of this area. This paper aims to fill these gaps.

In this article, I start by synthesizing empirical findings concerning gender differences in mental health and their social determinants in sociological studies. Next, I discuss inadequacies remaining in this subject of investigation. I provide a general discussion on the gaps in the literature, and synthesize feminist critiques of mental health research that primarily concern the omission of women's standpoints. Following this discussion, I introduce key concepts in the political economy of health and anthropology that can be applied to fill the gaps, and then suggest a new framework for the study of gender and mental health based on the integration of insights from different approaches.

2. Methods

I searched a great number of electronic databases, journals, and books to explore the literature on gender and mental health. First, I searched electronic databases, such as Sociological Abstract, PsycINFO, ProQuest, and Jstor, by setting "gender and mental health," "gender and mental," "gender and distress," and "women and mental health" in titles or keywords. Second, articles and references in textbooks on mental health, such as *Handbook of the Sociology of Mental Health* (edited by Aneshensel and Phelan 1999) and *A Handbook for the Study of Mental Health* (edited by Horwitz and Scheid 1999), were also used for reviewing the literature. Third, several journals in health areas, such as *Sociology of Health and Illness*, *Journal of Health and Social Behavior*, *Social Science and Medicine*, *Women and Health*, and *Culture, Medicine, and Psychiatry* were either browsed in electronic databases or hand-searched. Finally, the bibliography in each item found in the above searches was also browsed for relevant references.

3. Gender Differences in Mental Health and Their Determinants: The Sociological Tradition

Gender differences in mental health status have been the subject of scholarly debates. Nevertheless, a great number of studies in social psychological research support the finding that women are more likely than men to be mentally ill (Aneshensel 1992, Caldwell, Pearson, and Chin 1987, Dohrenwend and Dohrenwend 1974, Gove 1972, 1987, Gove and Tudor 1973, Mirowsky and Ross 1986). For example, Gove and Tudor (1973) find that women uniformly have higher rates of psychiatric treatment in mental hospitals, inpatient psychiatric treatment in general hospitals, and outpatient care in psychiatric clinics than men. Aneshensel (1992) and Mirowsky and Ross (1986) also find that, in relation to men, women report higher average levels of depression and anxiety. Several studies, (e.g., McGrath et al. 1990, Bebbington 1996, Nolen-Hoeksema 1990, Ussher 1991) also identify depression as a problem that afflicts women particularly.

Why do women outnumber men in the population that has mental problems? To investigate this subject, sociologists adopt mainly two approaches. One examines gender differences in personal characteristics (such as vulnerability, personality traits, self-concepts, coping strategies and available resources) and their effects on mental health. The second stresses the structural factors that produce gender inequality in society, and treats such forces as a major cause of the elevated status of one sex's rate of mental illness relative to the other's. Family structure, employment status, housework load, multiple roles, and poverty exemplify these structural factors. Because of sociologists' primary interest in understanding the structural factors of social problems, such as gendered distress, the second approach makes up most studies concerning this subject. Below, I synthesize some of the major findings of these two approaches.

Gender Differences in Personal Characteristics as the Causes of Gendered Distress

Adopting the first approach, for instance, Newman (1986) and Thoits (1986) attribute the causes of gender differences in mental health to the differential vulnerability and responsiveness of men and women. Both of their studies provide evidence that women

are more vulnerable than men to psychological distress and depression. In another study, Zukerman (1989: 442-443) finds that women have less confidence, self-esteem, self-sufficiency or coping ability, and public speaking/leadership abilities than men, leading to the greater number of reports that attributes symptoms of depression, anxiety, and anger to women when under stress. Moreover, Turner and Marino (1998) report that higher levels of social support are related to lower levels of distress among both men and women. Women, however, exhibit more positive social support as well as more depressive symptoms and distress than their male counterparts.

Structural Factors of Gender Inequality as the Causes of Gendered Distress

The second approach, the so-called “social causation model,” treats social structures and social relations as the major determinants of mental health. Family structure (including parenthood and marital status) and employment are two of the most frequently examined variables in this approach. According to Broman (1991), in general, married people have greater levels of psychological well-being than the non-married, but married women have higher rates of mental illness than married men and single women. In addition, amount of housework and number of children are two major family conditions that have an important negative influence on married women’s mental health (Lennon and Rosenfield 1992). Husbands’ support and sharing of responsibilities for childcare and housework help reduce married women’s risk of mental illness, especially for employed women with multiple roles (Dennerstein 1995). However, the sharing of domestic work has been found to increase a husband’s degree of depressive symptoms (Glass and Fujimoto 1994).

A few studies have discussed the influence of family structure on African Americans’ mental distress and the gender differences that emerge as a result of this influence, although the findings remain inconsistent (Ball and Robbins 1986, Reskin and Coverman 1985, Zollar and Williams 1987). Broman (1991) argues that African Americans’ family structure is different from that of White families, a factor that is often overlooked in discussions of family stress. In Asian families, it is believed that close family ties provide important support for dealing with psychological problems (Sue and Morishima 1982, Uba 1994). Wolf (1997) finds, however, that the strong family ideology

pervading Filipino families imposes patriarchal power on young girls and causes serious mental problems.

As for the association between employment and mental health, women's participation in the paid labor force has been found to be an important contributor to their general psychological well-being (Bernard 1984, Dennerstein 1995, Glass and Fujimoto 1994). However, in comparisons of employed women with housewives and men, the reliability of this contention requires reservation because the empirical data have been quite inconsistent. Some studies find that although employed women have lower levels of distress than housewives, the two groups of women are more distressed than employed men (Radloff 1975). Others find no difference between employed women and housewives (Cleary and Mechanic 1983, Pearlin 1975). Still others find that employed women do not differ from employed men in levels of distress (Gore and Mangione 1983, Kessler and McRae 1982).

To examine further the conditions under which employment contributes to or constrains women's mental health, some researchers have investigated various control variables that theoretically modify this association. Their findings illustrate that job control, autonomy, and complexity enhance employed women's psychological well-being (Hall 1989, Lennon and Rosenfield 1992, Pugliesi 1992, Rosenfield 1989). Employment also has interaction effects with family structure on women's mental health. Working for pay buffers women's marital stress, whereas parenting has a negative and exacerbating effect on work-related stress (Kandel et al. 1985). Such interaction effects between women's paid work and unpaid housework are generally addressed in the literature as an issue that concerns how women's multiple roles influence their mental health. Empirical research does provide evidence that certain sets of multiple roles are beneficial for women's psychological well-being (Thoits 1983, Pugliesi 1992). Nevertheless, the consequences of multiple role obligations are not uniformly positive. While women who engage in paid work in most cases still perform the vast majority of domestic work, multiple roles for them could lead to extra burdens and consequently cause higher rates of distress and depression as compared to employed married men and employed single women (Cleary and Mechanic 1983, Pugliesi 1992). In particular, employed married

women with young children experience higher levels of distress than their childless counterparts or comparable men (Cleary and Mechanic 1983, Thoits 1986).

4. Inadequacies in the Literature

As noted above, empirical research has established abundant sociological knowledge about gender and mental health. Nevertheless, some gaps remain in the literature. I first discuss these gaps from a sociological perspective and then synthesize feminist critiques on mental health research.

General Discussion

First, social contexts have been ignored to a large extent in sociological studies of mental health (Hall 1989). Mental health studies tend to be empirical examinations of specific variables. This tendency often overlooks the social contexts and the larger societal structure within which the social experience of mental distress is produced. Although a few sociologists have attempted to consider social context and structure in mental health research (e.g., Broman 1991, Wolf 1997), the dynamic social context of emotional life remains ignored in the literature. For instance, we know that marital status affects men's and women's mental health differently, but studies investigating this issue have rarely provided explanations concerning *why* and *how*. In other words, in the literature, we often obtain the information in such a way that when an association, or a specific direction of association, exists between two variables, we hardly know the dynamic context that produces this association. The major research method of the sociology of mental health – large-scale surveys – might make this goal difficult because quantitative approaches are not designed for the capture of dynamic contexts surrounding the inquiry. In a study of Filipino families, Wolf (1997) provides some evidence that a qualitative approach can help contextualize the social dynamics of emotional life, which are what quantitative measurements fail to reveal. She thus advocates more in-depth qualitative investigations of immigrant mental health.

Second, diversity of structural intersection is overlooked.¹ In general, sociological studies of mental health are based on the social experiences of the White middle-class. When ethnicity is discussed, it is often Blacks rather than other ethnic groups that provide a reference point for the White population. Experiences of lower-class people are also rarely discussed. In my view, mental health research to some degree is the study of the oppressed, because mental illness is often found in disadvantaged populations, such as women, minorities, the unmarried, the elderly, the uneducated, the unemployed, and the poor (Mirowsky and Ross 1986, Portes and Rumbaut 1996, Vega and Rumbaut 1991). While ethnicity and class, along with gender, are all important structural intersections that produce inequalities, the omission of ethnicity and class in the study of gender and mental health leaves these sources of inequalities and their impact on psychological well-being unexamined.

Feminist Critiques of Mental Health Research

Feminist critiques of mental health research focus mainly on three issues: gender-biased perceptions of researchers and medical professionals; the othering of women; and the neglect of women's subjective experiences.²

First, gender stereotypes exist among mental health professionals and researchers. In an early study, Broverman and her associates (1981) point out that mental health professionals convey gender stereotypes in their clinical judgment. These scholars illustrate that in clinicians' views, a "healthy adult" is similar to a "healthy male" and that an "unhealthy adult" is most similar to a "healthy female." In another study, Rosewater (1985) finds that according to the diagnostic criteria in DSM III, women suffering from abuse may be mistakenly labeled as mentally ill.³ Moreover, because men comprise the majority of mental health professionals and researchers, their measurements create a

¹ Social inequality is produced not solely by gender or other single systems such as ethnicity or class. Rather, it is formed by an intersection of these structural factors, shaping diverse individual standpoints in society and varied life experiences.

² In a society that privileges men, women are often treated as "the other," differentiated from "the norm." "Othering" is therefore used to describe this differentiation by the dominant group.

³ DSM III, Diagnostic and Statistical Manual of Mental Disorders, third edition, was published in 1980 by the American Psychiatric Association to set forth diagnostic criteria, descriptions, and other information that could facilitate the diagnosis of mental disorders.

greater number of men's perceptions of mental health than of women's. Showalter (1985) also argues that professional conceptions of mental health and insanity are fundamentally gendered. She points out that madness is a female malady, not only because women are statistically more likely to have psychiatric disorders, but also because insanity is an essentially feminine malady. In short, feminist scholars highlight the gender bias of mental health professionals in their labeling of mental disorders (i.e., their tendency to presume that women are emotional, irrational, hysterical, and even "abnormal").

Similar bias can also be found in empirical work. For instance, in a study about women patients who receive psychiatric treatment for neurotic disorders, Miles (1988) argues that women are unable to distinguish their own emotional disturbance from mental illness. In her view, the anxiety and the depression these women report at clinics are not "real" mental illness but problems they can themselves avoid. Miles' statement implicitly suggests women's inability to distinguish their "emotional problems" from "mental illness." This viewpoint devalues women's competence, implying their "irrational" predisposition; it also reinforces the perception that bio-medical knowledge comprises the "orthodox" judgments of mental illness, a perception that overlooks individuals' subjective experiences of distress in social life.

As mentioned earlier, women receive higher rates of psychological treatment than do men (Gove and Tudor 1973). Compared to their male counterparts, women are more likely to report depressive symptoms because of, on the one hand, their lack of confidence and self-coping ability and, on the other, their lower self-esteem (Zukerman 1989). This tendency might lead to the high frequencies with which women seek professional help. Nevertheless, sociologists also find that women suffer more psychological distress than men (Aneshensel 1992, Caldwell, Pearson, and Chin 1987, Dohrenwend and Dohrenwend 1974, Gove 1972, 1987, Gove and Tudor 1973, Mirowsky and Ross 1986). Miles' concluding remarks that women's depressive and anxious "symptoms" need no "real" clinical attention convey a bias in her judging of women's emotional problems. By perceiving women's help-seeking behavior as a "wrong conduct," Miles' statement shows a "blame-the-victim" attitude. This viewpoint not only reinforces gender stereotypes; it also tends to normalize women's psychological

sufferings and leaves the socio-structural roots of their “problems” unexamined. As Miller (1976: 126) notes, “Women are not creating conflict; they are exposing the fact that conflict exists.” The social contexts of gendered mental distress therefore should be central to the sociological study of gender and mental health.

Second, women are often treated as the reference group of men in studies of gender and mental health. As Hall (1989) points out, most social psychological studies of mental problems were done about men, and women subjects tend to be regarded as a comparison for them. Under the umbrella of “gender,” women are treated as “the other,” a reference to the group of men. This tendency is particularly obvious in the study of occupational stress. Whenever women are studied as an independent group, it is often women’s family conditions rather than their occupation that are investigated. Women are frequently analyzed in terms of their “place” in society—the family. Furthermore, women’s mental health as a subject is mostly subsumed within the general issue of gender differences but is not treated as an independent matter in the literature. The neglect of women per se not only court danger of over-generalizing gender differences in mental health but homogenizes women and ignores their diversities, as well. Women of various ethnicities, classes, sexualities, nationalities, and cultures have different life experiences and perceptions of mental health. They may use different terms to describe their mental problems, adopt different coping strategies in reaction to them, and practice different styles of help-seeking behavior. While studies of gender differences of mental health have recognized that in most cases, women are more vulnerable than men to mental problems, it is necessary to investigate how women from different standpoints differ in their perception and experience of mental health.

Third, women’s subjective experiences of mental health are often overlooked. In her book, *Understanding Depression*, Stoppard (2000) points out that the meaning of depression to a large extent depends on the social context in which the term is used and on who uses it. She argues that researchers’ notions of depression, based chiefly on positivist perspectives, do not necessarily reflect subjects’ depressive experiences. In this regard, Stoppard develops different meanings for terms and thereby distinguishes between depressive disorder (a disorder defined by mental health professionals and

researchers), depressive symptoms (a person's responses on a questionnaire designed by clinical researchers to assess depression), and depressive experiences (people's subjective experiences in everyday life that are self-reported as depression). She criticizes mental health researchers for their tendency to adopt positivist perspectives and measurements and consequently for their neglect of women's experiences as perceived from these women's own standpoint (Stoppard 2000).

5. Filling Gaps: Understanding Socio-Cultural Contexts of Gendered Distress

The sociology of mental health has produced abundant empirical knowledge and discussions concerning gender differences in mental health and their social determinants. As noted above, however, the literature has also left some gaps to be filled. Some of the gaps result from the shortcomings attributable to the major methods that sociologists who are interested in this topic used to adopt (e.g., quantitative methods' deficiency in the discovery of dynamic social contexts that produce distress); other gaps can be overcome by more cautious investigations (e.g., the need to compare groups in different social locations and to emphasize women's subjective experiences). To build a framework that creates an understanding of gendered distress that is superior to the understandings thus far developed, I suggest that we incorporate into our research concepts from the political economy of health and the anthropology of mental health.

Insights from Theoretical Perspectives

The political economy approach to health emphasizes structural factors and power relations that produce inequalities in well-being, two phenomena that have been overlooked in sociological studies of mental health. The anthropology of mental health, or what some anthropologists call "cultural psychiatry," highlights the importance of cultural meanings in the labeling of both mental illness and abnormal behavior.

Political Economy of Health

The political economy approach has been used by many feminists (e.g., Doyal 1979, 1995, Fee 1982, Shiva 1994) in the examination of the interlocking social, political, and economic factors that impair women's health. Drawing on Marxist perspectives, proponents of the political economy approach argue that the social production and distribution of health and illness cannot be separated from larger social, economic, and medical systems. Under the operation of capitalism, not everyone is affected equally by the illness-producing process. For instance, we can find class differences in morbidity and mortality, differential health risks of specific occupations, and unequal health status in developed and under-developed societies. Even medical organizations and practices, whose goal is supposed to be the production of health, often work in the interests of capital (Doyal 1979).

The notion of *power* is central to the political economy approach to health. According to Doyal (1995), the contemporary crisis in medicine is deeply rooted in the nature of capitalism, as both an economic and a social system. As an economic system, medical institutions function according to the logic of capitalism, which benefits the medical profession and industry more than patients. Furthermore, as a social system dominated by men and medical/scientific knowledge, the medical setting is an arena within which power relationships are omnipresent. In other words, economic power dominates the operation of the medical industry, while social and professional power determines the definitions of health and illness that are used in medicine. In a similar vein, in the larger society, various forms of power determine the distribution of resources, a fact that leads to unequal social and health statuses. The political economy of health approach, therefore, aims to investigate the power structure that is shaped by interlocking economic, social, political, and cultural forces.

Feminists who adopt the political economy of health approach emphasize the importance of social contexts and their impact on women's health. For example, Becker and Nachtigall (1992), Fee (1983), Hubbard (1995), and Lowis and McCaffery (2004) all argue that women's health has been over-medicalized, a phenomenon that entraps women's bodies within a male-dominant medical gaze and control. Women's

“problems,” especially reproductive-health issues such as pregnancy, childbirth, and menopause, have been medicalized. Women as a group thus tend to be defined by their biological sex and reproductive potential in medicine.

In addition to medical power, how larger structural (political, social, economic, historical, and cultural) factors affect women’s health has also been widely discussed in the political economy approach of health. For instance, ecological feminist Shiva (1994) demonstrates how capitalism, imperialism, and colonialism can damage the environment and consequently endanger women’s survival and health in the Third World. Thomas (1994) argues that poverty, an indicator of economic inequality, constrains women’s life chances and places them at great risk for many stress-related illnesses. She therefore advocates the position that sociologists examine the stratification hierarchies, social relations, and power structure that prevent women and other disadvantaged groups from equal access to health care.

Moreover, Krieger and Fee (1994: 18) maintain that the way gender, as a social reality, intrudes into the body and transforms our biology is usually ignored by sociologists. They illuminate this statement by referring to a widely acknowledged discrepancy: in childhood, boys and girls receive different (gendered) expectations about exercise and, thereby, develop different body builds. The biological category “female,” as a result, actually carries and is shaped by cultural norms of gender that are differentially experienced according to ethnicity and social class. Krieger and Fee therefore argue that patterns of health and disease are highly related to how people live in the world, and thus they insist that women’s lives and the social contexts (the intersection of gender, social class, and ethnicity) within which women live should be carefully examined (*ibid.*). In other words, from the perspective of political economy of health, macroeconomic structure, class, ethnicity, and paid and unpaid work are all considered important contextual dimensions that affect women’s health and lives (Bartley et al. 1992, Gallin 1989, Graham 1990, Kynaston 1996, Messias et al. 1997).

Cultural Anthropology

Anthropological studies of mental health highlight the importance of cultural values in the construction of mental-illness meanings. As many anthropologists have observed, each society has distinct beliefs about normal and abnormal behavior, and the concepts of emotion, self and body, and general illness differ significantly among different cultures (Fabrega 1990, 1992, Good 1977, Lutz and White 1986, Marsella and White 1982, Kleinman 1988, Marsella et al. 1985). Culture is therefore critical in understanding how mental disorder is perceived, experienced, and expressed in everyday life (Kleinman 1988: 3). In other words, concepts of mental illness are not fixed but specific to a culture at a given time in its history (Foucault 1965).

Adopting this viewpoint, many studies in both anthropology and sociology have discussed how culture in general shapes people's views of mental illness. For instance, Asian views of mental health and illness have been frequently discussed in the literature to demonstrate an "alternative" perspective from the majority U.S. or Western culture. Agbayani-Siewert and his colleagues (1999) point out that the notion of collectivism in Asian culture prevents people from seeking professional help for their mental problems, because admission of such illness would make the people who are admitting to the problem "lose face" in front of others. Lin and Cheung (1999) argue that, because Asian traditions view the body and mind as unitary rather than dualistic, people tend to focus more on physical discomfort than on emotional symptoms. Chinese views on the harmony between nature and the universe, as well as on the balance of yin and yang forces in health, also have been discussed in explorations of cultural differences that characterize perceptions of mental illness (Kuo and Kavanagh 1994, Leung 1998). The overrepresentation of somatic complaints and neurasthenia, a phenomenon called somatization of mental distress, has been found in many Asian communities (Gaw 1993, Kawanishi 1992, Kleinman 1988, Kuo and Kavanagh 1994). Undoubtedly, culture plays an important role in the ways mental health and illness are perceived, experienced, and interpreted.

Re-thinking Gender and Mental Health

Both the political economy of health and cultural anthropology bring insights into the study of gender and mental health. First, the political economy approach to health highlights the structural factors that shape social and health (including mental health) disparities. It emphasizes power structure and power relations as constituting the most important factor that causes gender inequality and consequent differences in men's and women's health status. From this viewpoint, power structure and relations are interconnected, as (socio-cultural) structure is itself inequality, produced by power relations and meanwhile shaping power relations.

The political economy of health's emphasis on power structures and power relations corresponds to feminists' concern about women's disadvantaged status in society and academic work. According to Vannoy (2001: 2), "Gender is about the relationship between women and men and that relationship is about power."⁴ Therefore, a study of gender and mental health has to examine the power relations between women and men, the socio-cultural structure and contexts within which this inequality is produced, and their consequent effects on individuals' psychological well-being.

Nevertheless, women are not the only "other" that has been excluded from power, and not all women are more powerless or disadvantaged than men. Gender intersects with other aspects of structure, such as ethnicity, class, and sexuality, in the shaping of both social inequality and life experiences. As feminist standpoint theorists (e.g., Harding 1986, Hartsock 1983, Smith 1987) argue, there is no single standpoint that women occupy. Various locations can produce very diverse life experiences, and ethnicity and class are just as significant as gender in shaping these differences (Harding 1986, Hartsock 1983, Smith 1987). For example, non-White men may face worse life chances than White women, and middle-class White women may be more advantaged than both of their lower-class male and female counterparts. Intersectional structural positions

⁴ Although many feminists (such as Vannoy and Doyal) highlight power as an essential element in the production of gender inequality, they do not intend to reduce gender to a "pure" power problem. Rather, they acknowledge that gender is also a cultural pattern from which both women and men suffer because their behavior (including health and mental-health behavior) is greatly shaped by society (Doyal 1995, Krieger and Fee 1996).

shape not only individuals' diverse standpoints in society but also their varied experiences of social life and mental distress.

As I mention above, mental illness is often found in disadvantaged populations, such as women, minorities, the elderly, the uneducated, the unemployed, and the lower-class. This fact suggests that the sociology of mental health is to some extent a study of social inequality and its consequences, of which interlocking structural forces are central. It is therefore important to extend investigation of power structure and relations beyond gender, onto other aspects of diversity, such as ethnicity and class, as well as onto their impact on mental health.

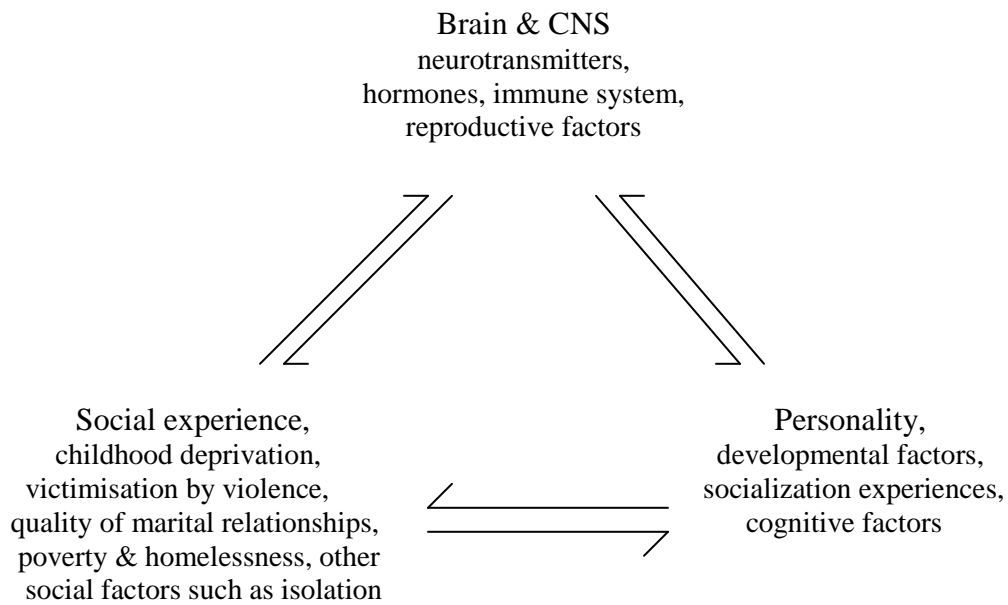
Second, the anthropological perspective on mental illness reminds sociologists about the variations in the meanings attached to psychological problems in different cultural groups, including gender.⁵ The concepts and measurements developed in Western societies or primarily applied to the White population may not be appropriate for efforts to interpret the phenomena in non-Western countries or non-White groups. Similarly, as Stoppard (2000) criticizes, men's knowledge of mental health and illness may not reflect how women experience and interpret their distress.

Some sociologists (e.g., Agbayani-Siewert et al. 1999, Brown et al. 1999, Lefley 1999, Takeuchi, Uebara, and Maramba 1999) have stressed the importance of culture in mental health research. Studies have shown how individuals' social relations and psychological well-being can be affected by specific ethnic cultures, such as the equalitarianism of African American couples (Broman 1991) and the close family ties among Asian American groups (Sue and Morishima 1982, Uba 1994, Wolf 1997), cultures that shape group members' mental health experiences in a way that differs significantly from that of the Euro American population. Moreover, as mentioned earlier, feminist critiques of mental health research have also called for more scholarly attention to women's experience of distress. Regardless of these efforts, cultural dimensions of mental health and illness remain under-examined in the sociology of mental health.

⁵ In studies of cultural psychiatry, anthropologists focus mostly on the cultural meanings of distress in non-White and non-Western communities. Because gender can also be a cultural pattern, it is equally important to examine how women differ from men in their interpretations of, and society's meanings underlining mental distress.

For example, in *Mental Health of Indian Women: A Feminist Agenda*, Davar (1999: 87) examines research on women’s mental health and synthesizes a bio-psycho-social model (see Figure 1). Rejecting the reductionism of any single dimension of this model, Davar calls for a sophisticated understanding of women’s mental distress that takes into account complex contextual factors, especially psycho-social causes (Ibid.: 74-89).

Figure 1: Bio-psycho-social model for depression (Davar 1999: 87)



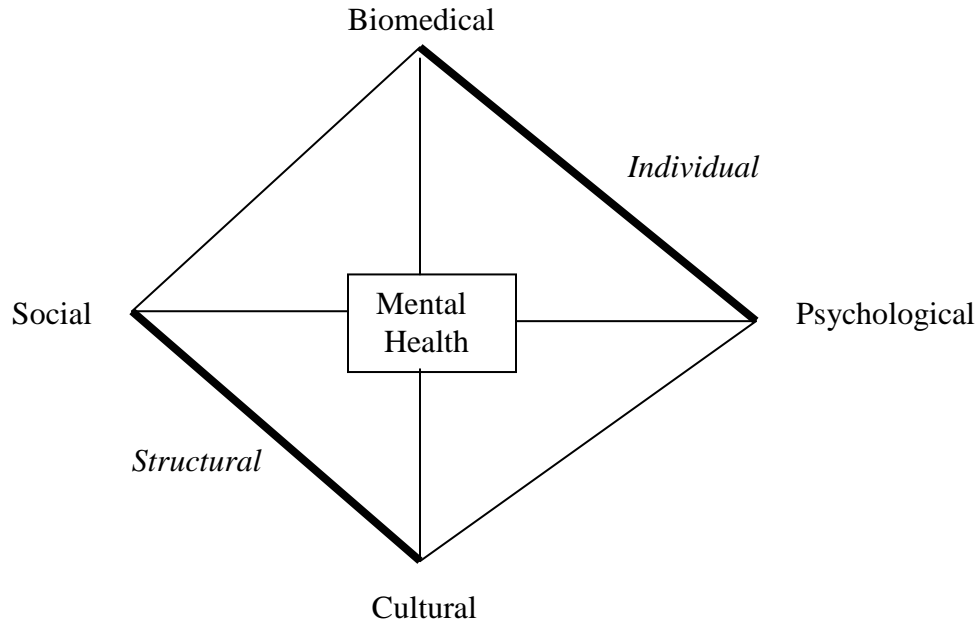
In my view, this insightful argument fails to account for an important element—that is, the role that culture plays in the contest of mental distress.⁶ According to Chakraborty (1992: 2), “Nothing human can be taken out of culture and studies in isolation.” Takeuchi, Uehara, and Maramba (1999: 565) also emphasize that “cultural factors are critical to understand access to mental health services, the proper screening and diagnoses that lead to treatment, and the actual effectiveness of treatment.” While the psycho-social dimension of distress has been broadly explored in the sociology of mental health, cultural aspects of this issue are relatively neglected (Agbayani-Siewert et. al. 1999,

⁶ Although Davar (1999) acknowledges the importance of culture in her book (mostly in Chapter Four), she does not include this dimension in her synthetic model.

Brown et al. 1999, Fabrega 1992, Lefley 1999, Takeuchi, Uehara, and Maramba 1999, Triandis 1993). As Lefley (1999: 584) argues, culture can profoundly affect not only the experience of mental illness and health but its development, as well. Triandis (1993) too insists that psychological well-being is associated with individuals' cultural values and beliefs.

Following these scholars, who acknowledge the importance of culture in mental health studies, I modify Davar's model and create one that is diamond-shaped and includes biomedical, psychological, social, and cultural factors of mental distress (see Figure 2). As illustrated in this figure, biomedical and psychological aspects constitute the individual dimension of mental health, while social (e.g., systems, organizations, systems of stratification, social positions and relations) and cultural (e.g., symbols, meanings, values) factors make up its structural facet. I argue that the lower half of this diamond model, the psycho-social-cultural triangle, ought to be the major focus of mental health research in social science.

Figure2: Diamond-Shaped Model of Mental Health



As Gallin (1989) states, an explanatory model of the social impacts on women’s health must tie macro and micro phenomena into a dynamic whole that allows for contextual effects and variations. This assertion holds true in the study of gender and mental health, and my diamond-shaped model illustrates an effort to achieve this goal. While both women’s and men’s subjective discontent to a large extent mirrors certain social inequalities and cultural patterns in a gendered context, it is particularly important to bridge structural factors and individuals’ experiences in the examination of gendered mental health issues. By so doing, sociologists are able to fill the gaps in the study of gender and mental health, and thus acquire more comprehensive understanding about the contextual effects and variations of gendered distress.

6. Conclusion: Beyond Gendered Distress

By reviewing the literature on the study of gender and mental health, this article not only synthesizes current knowledge about this subject but also highlights important issues and directions for future research. As demonstrated in this paper, gendered distress and the structural contexts within which it is produced are involved in social and cultural forces that are broader and more complex than a simple gender factor. Structural systems other than gender, such as ethnicity and class, intersect with gender in creating individuals' varied social positions. This intersectional diversity shapes both men's and women's standpoints in society, differences in their social and emotional lives, and variations of the cultural meanings concerning their experience. The interplay of social and cultural contexts and its impact on men's and women's mental health, therefore, should be a central concern in future research so that a more sophisticated understanding of this subject can be arrived at.

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