Appendices

Appendix 1: Risk and Protective Factors

A woman's health and wellbeing is determined by the natural, human made and social environments (such as families, social networks and associations) (AIHW 2005). The causes of mental illness are not clear, but a range of risk and protective factors are thought to influence mental health and wellbeing. These factors may be individual (specific to the woman), contextual (a product of her environment), or the result of the interaction between a woman and her environment (AIHW 2007). It is imperative to address the determinants of poor mental health and wellbeing in order to prevent the onset of mental illness.

See Figure 1 below for a visual representation of the risk and protective factors as outlined in The Melbourne Charter.

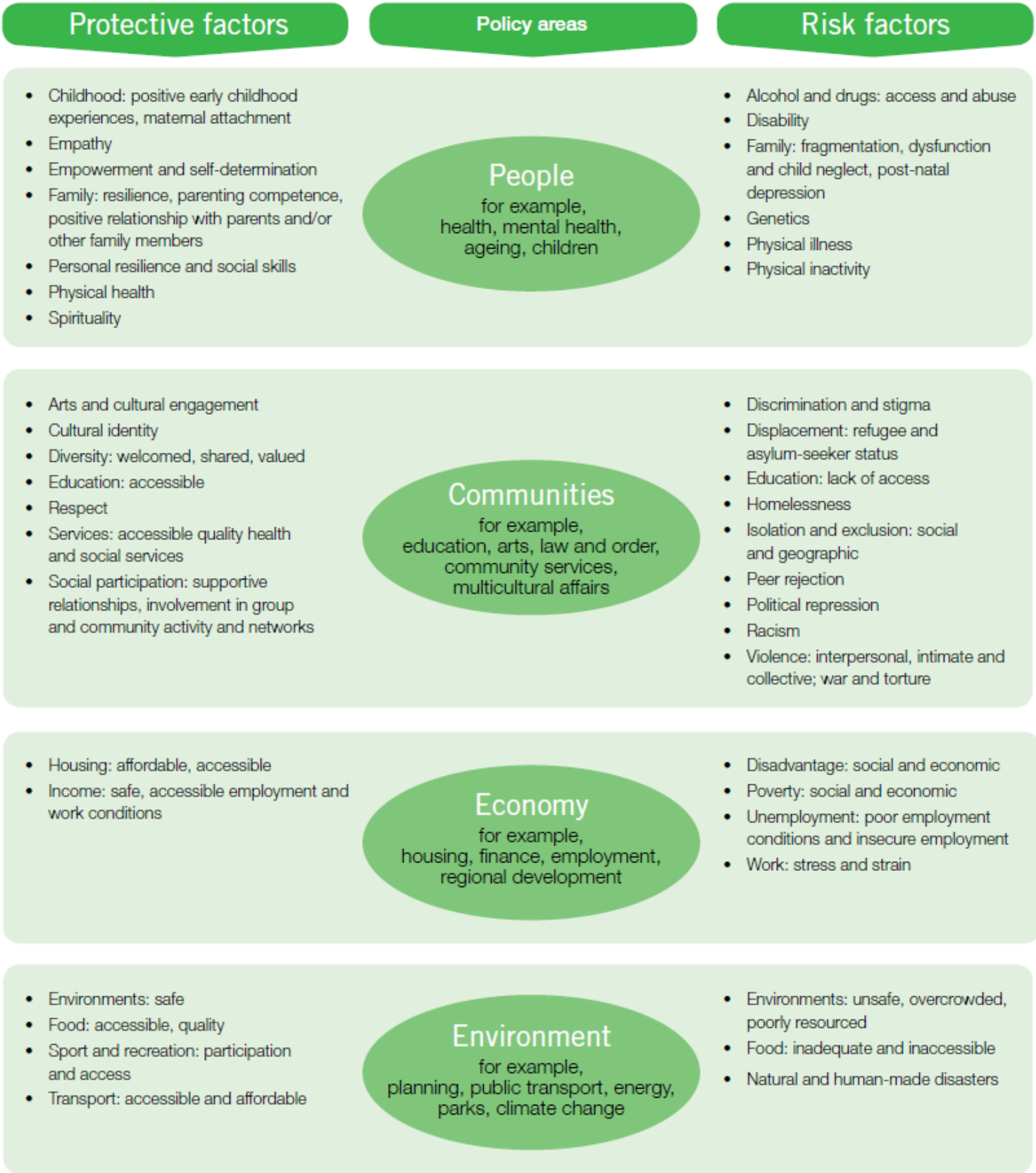

Figure 1 shows risk and protective factors identified in The Melbourne Charter for Promoting Mental Health and Preventing Mental and Behavioural Disorders

Below is a list of resources that will provide in depth information around specific risk and protective factors.

Risk Factors

Physical Illness

Women and Diabetes: Gender Impact Assessment (Women's Health Victoria 2010)
http://whv.org.au/static/files/assets/abec140a/Women_and_diabetes_GIA.pdf

Women and Cardiovascular Disease: Gender Impact Assessment (Women's Health Victoria 2008)
http://whv.org.au/static/files/assets/b4b6e0f1/Women_and_cardiovascular_disease_GIA.pdf

Displacement

The Mental Health of Migrants and Refugees: Facts and Statistics (Mindframe 2012)
http://www.mindframe-media.info/site/index.cfm?display=84368

Disability

The Sick State of Health for Women With Disabilities (Salthouse 2005)
http://www.wwda.org.au/health1.htm

Women and Mental Health: Issues Paper (Women's Health Victoria 2009)
Women with Disabilities p.20
http://whv.org.au/static/files/assets/0b6d59c7/Mental_Health_Issues_Paper_Nov_09.pdf

Environments

Women and Climate Change: Gender Impact Assessment (Women's Health Victoria 2009)
http://whv.org.au/static/files/assets/c192accd/Women_and_climate_change_GIA.pdf

Food

Women and Food Insecurity: Issues Paper (Women's Health Victoria 2010)

http://whv.org.au/static/files/assets/64793bc2/Women_and_food_insecurity_issues_paper.pdf

Discrimination

Ethnic and Race Based Discrimination as a Determinant of Mental Health and Wellbeing (VicHealth 2007)
http://www.vichealth.vic.gov.au/Publications/Freedom-from-discrimination/Ethnic-and-race-based-discrimination-as-a-determinant-of-mental-health-and-wellbeing.aspx

Violence

Prevention of Violence Against Women in the Eastern Metropolitan Region of Melbourne (Women's Health East 2011)
http://www.whe.org.au/newsite/documents/2011-11-29%20PVAW%20Overview%20Formatted%20min%202.pdf
Women and Violence: Issues Paper (Women's Health Victoria 2009)
http://whv.org.au/static/files/assets/9b67374f/Women_and_violence_issues_paper.pdf
Violence Against Women in Australia: Research Summary (VicHealth 2011)
http://www.vichealth.vic.gov.au/Publications/Freedom-from-violence/Violence-against-women-in-Australia-research-summary.aspx

Alcohol and Drugs

Women and Alcohol: Gender Impact Assessment (Women's Health Victoria 2010)
http://whv.org.au/static/files/assets/9502f094/Women_and_alcohol_GIA.pdf

Women and Drugs: Gender Impact Assessment (Women's Health Victoria 2008)
http://whv.org.au/static/files/assets/030e652b/Women_and_drugs_GIA.pdf

Work

Mental Health and Work: Issues and Perspectives (Auseinet 2002)
http://www.vichealth.vic.gov.au/Publications/Economic-participation/Mental-Health-and-Work.aspx

Protective Factors

Social Participation

Opportunities for Social Connection (VicHealth 2010)
http://www.vichealth.vic.gov.au/Publications/Social-connection/Opportunities-for-social-connection.aspx

Social Inclusion as a Determinant of Mental Health and Wellbeing (VicHealth 2005)
http://www.vichealth.vic.gov.au/en/Publications/Social-connection/Social-Inclusion-as-a-determinant-of-mental-health-and-wellbeing.aspx

Technology, Arts and Social Connection (VicHealth 2011)
http://www.vichealth.vic.gov.au/Publications/Social-connection/TASC-Technology-Arts-and-Social-Connection.aspx

Benefits of Group Singing on Community Mental Health and Wellbeing (VicHealth 2011)
http://www.vichealth.vic.gov.au/Publications/Social-connection/Benefits-of-group-singing-for-community-mental-health-and-wellbeing.aspx

Housing

Housing and Health: Research Summary (VicHealth 2011)
http://www.vichealth.vic.gov.au/Publications/Health-Inequalities/Housing-and-health-research-summary.aspx

Sport and Recreation

Women and Physical Activity: Gender Impact Assessment (Women's Health Victoria 2010)
http://whv.org.au/static/files/assets/5cdddc1f/Women_and_physical_activity_GIA.pdf

Participation in Physical Activity (VicHealth 2010)
http://www.vichealth.vic.gov.au/Publications/Physical-Activity/Sport-and-recreation/Participation-in-physical-activity.aspx

Personal Resilience and Social Skills

Women and Body Image: Gender Impact Assessment (Women's Health Victoria 2009)
http://whv.org.au/static/files/assets/737357a3/Women_and_body_image_GIA.pdf

Spirituality

How does freedom of religion and belief affect health and wellbeing? (VicHealth 2011)
http://www.vichealth.vic.gov.au/Publications/Freedom-from-discrimination/Freedom-of-religion-and-belief.aspx

Income

Women's and Financial Security: Gender Impact Assessment (Women's Health Victoria 2008)
http://whv.org.au/static/files/assets/92c6e757/Women_and_financial_security_GIA.pdf

Access to Economic Resources as a Determinant of Mental Health and Wellbeing (VicHealth 2005)
http://www.vichealth.vic.gov.au/Publications/Economic-participation/Access-to-Economic-Resources-as-a-determinant-of-mental-health-and-wellbeing.aspx

Access to Services

Social Determinants of Health (SACOSS 2008)
http://www.sacoss.org.au/online_docs/081210%20Social%20Determinants%20of%20Health%20Report.pdf

Appendix 2: Mental Illness

Mental illness can have an impact on all aspects of a woman's life; this may include work or study, relationships, social networks and home responsibilities (Slade et al. 2009). Mental illness is a diagnosable illness that specifically interferes with an individual's cognitive, emotional and/or social ability. Different types of mental illness include depression, anxiety, psychosis, substance use disorder, eating disorders, schizophrenia and personality disorders (Commonwealth Department of Health & Aged Care 2000). Mental health issues and mental illness may be influenced by a combination of biological, psychological, social, environmental and economic factors (Commonwealth of Australia 2009c).

Mental health issues occur often as a result of life stressors. The distinction between mental health issues and mental illness is made on the basis of the severity and duration of symptoms. Mental health issues also have an impact on a person's cognitive, emotional and social abilities but differ as they may not meet the criteria for a mental illness (Commonwealth of Australia 2000).

Individuals with serious mental illness have a life expectancy on average of 10 years less than people without mental illness; their mortality rate is also 2.5 times the general population (DHS 2009).This may be because of the greater risk of developing physiological health problems such as high blood pressure, type 2 diabetes and also may be due to poorer access to healthcare (DRC 2006). People with a severe mental illness have a

Diagnosed forms of mental illness such as depression, anxiety, eating disorders and substance use disorders affect around 20% of the population, whilst forms of mental illness such as schizophrenia and personality disorders impact on around 3% of the general population (Andrews & Wilkinson 2002).

Recovery from mental illness involves the development of new meaning and purpose and a satisfying, hopeful and contributing life as the person grows beyond the effects of psychiatric disability. It is a personal process of changing one's attitudes, values, feelings, goals, skills and/or roles. The process of recovery must be supported by individually-identified essential services and resources (Commonwealth of Australia 2009c).

A description of a number of mental illnesses and symptomatic behaviours are provided in detail below.

NB This is not an exhaustive list. Within these categories there may be additional types/levels.

Mental Illnesses

Affective (Mood) Disorders

- Depressive episode
- Dysthymia
- Bipolar Disorder

Anxiety Disorders

- Panic Disorder
- Social Anxiety Disorder
- Obsessive-Compulsive Disorder
- Generalised Anxiety Disorder
- Posttraumatic Stress Disorder

Eating Disorders

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder

Psychotic Disorders

- Schizophrenia

Personality Disorders

Common Symptoms/Behaviours associated with Mental Illness

Self-Harm

Suicidality

Co-morbidity

Affective (Mood) Disorders

Depression

Depression is a mood disorder characterised by feelings of sadness, loss of interest or pleasure in nearly all activities, feelings of hopelessness and suicidal thoughts or self-blame (AIHW 2010b). It is classified as a condition that often comes and goes and is more likely at certain stages of the life cycle (AIHW 2010b). Depression occurs frequently with other psychological problems (Victorian Government 2009). Depression can occur due to a number of factors including genetic, environmental and social (AIHW 2010b). Depression may be commonly linked to a variety of unhealthy risk behaviours such as tobacco use, illicit drug use, alcohol abuse, eating disorders and obesity (AIHW 2010b).

Depression is more common among people who are economically vulnerable or who live in poverty, and this is predominantly women and children (WHO 2005b).

In recognition of the many risk taking behaviours that are associated with depression, as well as its high prevalence and public health impact on Australia, depression has been identified as a National Health Priority Area (AIHW 2010b). In Australia there are almost 800,000 adults who will experience a depressive illness in any given year. Depression is the third most common cause of illness among women (AIHW 2010b). Depression is the leading cause of years of life lost due to disability for women in Victoria (DHS 1999).

Different types of depression often have slightly different symptoms and may require different treatment and management. The main types of depression include:

- **Major depression** - a depressed mood that lasts for at least 2 weeks. This may also be referred to as clinical depression or unipolar depression.
- **Psychotic depression** - a depressed mood which includes symptoms of psychosis. Psychosis involves seeing or hearing things that are not there (hallucinations), feeling everyone is against you (paranoia) and having delusions.
- **Dysthymia** - a less severe depressed mood however it may last for years.
- **Mixed depression and anxiety** - a combination of symptoms of depression and anxiety (Beyondblue 2010a).

In Australia, depression is one of the major health problems for women, where 1 in 4 women will experience depression at some stage in their lives (Mental Health Matters 2009). Females aged 18-24 years are at the greatest risk of suffering from depression. There are twice as many women than men who suffer from depression at this age (AIHW 2010b).

In direct monetary terms, it is estimated that, in excess of $100 million is spent annually in health system costs associated with depression (AIHW 2010b). It is important to note that given the impact that depression has not only on the individual, but also on their family, friends, colleagues and society in general, the true burden is not possible to measure (AIHW 2010b).

Depression often co-occurs with social disadvantage, unhealthy lifestyle and social isolation. Women who experienced depression in young adulthood may continue to experience periods of depression through their life. This highlights the importance of early intervention and prevention and the need to focus on younger women (Women's Health Australia 2005).

Bipolar Disorder

Bipolar Disorder is the name used to describe a set of 'mood swing' conditions, the most severe form of which used to be called 'manic depression'.

Bipolar Disorder I is the more severe disorder – with individuals being more likely to experience mania, have longer 'highs', be more likely to have psychotic experiences and more likely to be hospitalised.

Bipolar Disorder II is generally viewed as less severe, with no psychotic experiences, and with episodes tending to last only hours to a few days; however studies suggest impairment is often as severe as in Bipolar Disorder I.

The high moods are called mania or *hypomania* and the low mood is called depression. It is important to note that everyone has mood swings from time to time. It is only when these moods become extreme and begin to interfere with personal and professional life that Bipolar Disorder may be present and medical consultation may be needed.

Women with Bipolar Disorder have a higher chance of significant mood changes during pregnancy and in the post-natal period (Black Dog Institute 2010).

Anxiety Disorders

Anxiety disorders are characterised by feelings of tension, unease, distress or nervousness (Department of Health 2009). Anxiety encompasses specific disorders such as panic disorder, agoraphobia, generalised anxiety disorder and obsessive compulsive disorder (Department of Health & Ageing 2007a). All of these disorders have similar physiological symptoms including a pounding heart, sweating, trembling, shaking and having difficulty breathing (WHO 2008).

Anxiety disorders are the most common mental disorders in Australia. Nearly 1 in 7 people will experience some type of anxiety disorder in any one year, approximately 1 in 6 women and 1 in 10 men (beyondblue 2009). It has been suggested that women and girls are socialised to be more empathetic and respond to the feelings of others, whereas men and boys are expected to be more independent and assertive. These social factors may affect a woman's susceptibility to an anxiety disorder (beyondblue 2009).

It is important to distinguish between anxiety as a feeling or experience, and an anxiety disorder as a psychiatric diagnosis. A person may feel anxious and stressed without having an anxiety disorder, however some people may experience ongoing anxiety for no apparent reason or may continue to feel anxious after a stressful event has passed (beyondblue 2009).

There are some anxiety disorders that are more common in women than men. Some of these include:

Panic Disorder

A panic attack involves an intense feeling of anxiety that seems like it cannot be brought under control. Panic attacks can include short bursts of:

- Feeling anxious
- Feelings of dread e.g. that something bad is going to happen
- Breathing difficulties e.g. shortness of breath
- Feeling lightheaded and/or nauseous
- Having tingles or chills
- Trembling or shaking
- Having chest pains or a tight feeling in the chest (beyondblue 2009).

Panic attacks tend to occur when a person is stressed and may be a one-off event. However for some people, an initial attack can lead to fears of another attack at another time. This can lead to a vicious cycle where the person is continually worried about another attack.

About 3 out of 10 people will experience at least one panic attack at some point in their life. If a person has a panic attack at least 4 times a month, they may be diagnosed as having a panic disorder. Around 3 per cent of the population has a panic disorder (beyondblue 2010b).

Social Anxiety Disorder

Social Phobia or Social Anxiety Disorder (SAD) occurs if a person experiences considerable anxiety and fear when in social or performance situations, where the person is exposed to unfamiliar people or they fear being scrutinised and judged by others, meaning they often avoid social interactions.

SAD may result in the fear of specific aspects of social situations including writing, speaking or eating in public, using public toilets, and being observed at work. Individuals with SAD can experience significant disruption to their lives and an overall decreased quality of life due to feeling unable to go out in public and developing intense distress when in social situations.

SAD commonly develops in adolescence and has been found to occur in 4.7% of Australian adults (Swinburne University 2011).

Obsessive-Compulsive Disorder

Obsessive Compulsive Disorder (OCD) refers to individuals experiencing ongoing unwanted/intrusive thoughts and fears that cause anxiety - often called obsessions. These obsessions make people feel the need to carry out certain rituals in order to feel less anxious and these are known as compulsions.

Common obsessions include:

- Fear of forgetting to do things e.g. turning off appliances or locking doors
- Fear of being contaminated by things that are unclean e.g. dirty cutlery, crockery, food, keys, door handles and toilets
- Fear of not being able to do things in an exact or orderly way
- Fear of becoming sick, having an accident or dying
- Intrusive thoughts about violence, accidents or sex.
-

Common compulsions may include:

- Concerns about personal hygiene, resulting in constant washing of hands or clothes, showering or brushing of teeth
- Constantly cleaning, tidying or rearranging in a particular way things at home, at work or in the car
- Constantly checking that doors and windows are locked and appliances are turned off
- Continually seeking reassurance by repeatedly asking questions of family and friends
- Hoarding items such as newspapers, books, food or clothes.

Initially following these compulsions can make people with OCD feel less anxious. However, the anxiety returns resulting in the need to carry out the ritual again – therefore, continuing the cycle.

OCD affects 2-3% of people in Australia at some time in their lives (Beyondblue 2010b).

Generalised Anxiety Disorder

Individuals with Generalised Anxiety Disorder (GAD) feel anxious on most days for a period of at least 6 months (beyondblue 2009). Worry occurs about real issues such as finances, illness or family problems - to the point where it can affect the person's everyday life. At times the worry is so great it leads to:

- Feeling edgy/restless
- Feeling tired
- Difficulty concentrating
- Muscle tension (sore back, neck or jaw, headache)
- Finding it hard to fall/stay asleep (beyondblue 2009).

GAD affects approximately 5% of people in Australia at some time in their lives (Beyondblue 2010b).

Post Traumatic Stress Disorder

Post Traumatic Stress Disorder (PTSD) may develop after an individual personally experiences or witnesses a traumatic event in which they felt fear, helplessness or horror. The person may subsequently experience continual triggering of intense memories of the event including flashbacks and nightmares (Better Health Channel 2012). It is also possible that there is a delayed onset of PTSD, where the symptoms develop more than 6 months after the event (Swinburne University of Technology 2012).

The symptoms of PTSD are severe, long lasting and may interfere with the person's work, family relationships and quality of life. PTSD can occur in association with other anxiety disorders, depression and substance abuse. PTSD has a higher prevalence in women (8%) than men (4%) (Swinburne University 2011).

Eating Disorders

An eating disorder is a serious mental illness, it is not a lifestyle choice or a diet 'gone wrong' or a fad. An eating disorder may be present when eating, exercise and body weight/shape become an unhealthy pre-occupation for a woman. Eating disorder diagnosis can be linked to low self esteem and an attempt to deal with underlying psychological issues through practising an unhealthy relationship with food (Eating Disorders Victoria 2009a). Types of eating disorders include anorexia nervosa, bulimia nervosa and binge eating disorder.

Eating disorders affect young women regardless of their socioeconomic and cultural backgrounds. One in twenty women report having an eating disorder and 1 in 4 women report knowing someone who has an eating disorder; anorexia nervosa is the third most common illness for adolescent girls in Australia (after obesity and asthma) (Eating Disorders Victoria 2010a). Body image has been identified as the top concern for Victorian girls aged 15-19 (Victorian Government 2008a).

Research suggests that 62% of adolescent girls who are classified as extreme dieters have depression (Victorian Government 2008a). Eating disorders affect 5% of the total Australian female population. Girls and women account for 94% of the total disease burden relating to eating disorders (Department of Health 2010).

Dieting is the greatest risk factor for the development of an eating disorder. Research findings suggest 68% of 15 year old females are on a diet, of these, 8% are severely dieting. Adolescent girls, who diet only moderately, are 5 times more likely to develop an eating disorder than those who don't diet, and those who diet severely are 18 times more likely to develop an eating disorder (Eating Disorders Victoria 2009a).

Negative body image in women can also be linked to eating disorders. In Australia, 1 in 20 adult women report having suffered an eating disorder in any given year (WHV 2009). Trends in Australia show that the number of girls and women with eating disorders is increasing and the average age of development of an eating disorder is becoming younger.

Anorexia Nervosa

The most common eating disorder that is associated with negative body image is anorexia nervosa. After obesity and asthma, anorexia nervosa is the most common disease in females aged 15-24. It is generally estimated that in Australia 2-3% of adolescent and adult females satisfy the diagnostic criteria for anorexia and bulimia nervosa (The Butterfly Foundation 2009). Anorexia nervosa is characterised by self starvation and excessive rapid weight loss which can result in a dangerously low body weight (CEED 2009). Some of the symptoms that are associated with anorexia nervosa include:

- A refusal to maintain weight at or above a normal weight for height
- An intense fear of gaining weight or becoming overweight

- A body image disturbance such as feeling 'fat' despite being underweight
- A loss of menstrual periods (CEED 2009).

Anorexia nervosa has an earlier onset than any other eating disorder. It is generally developed during adolescence, however, similar to all eating disorders it can begin at any stage of life (Eating Disorders Victoria 2009b).

Anorexia nervosa is the most fatal of all psychiatric illnesses; risk of completed suicide is particularly high; an individual with anorexia nervosa is at a significantly increased risk of completed suicide (CEED 2009).

Bulimia Nervosa

Another common eating disorder in women is bulimia nervosa. This is characterised by a cycle of binge eating followed by purging (self-induced vomiting) (CEED 2009). This cycle often occurs behind closed doors and the person affected attempts to keep their condition a secret. The incidence of bulimia nervosa in the Australian population is 5 in 100 (CEED 2009). Studies have indicated that only one tenth of the cases of bulimia are detected. The true incidence is estimated to be as high as 1 in 5 in the student population (CEED 2009).

It is common for people affected by bulimia nervosa to keep their disorder hidden for 8-10 years, at great cost to their physical and psychological health (Eating Disorders Victoria 2010b). Laxative/ diuretic abuse and over-exercising are also frequently used with bulimic sufferers. Repeated episodes of binge eating and purging often result in feelings of shame and self-hatred (CEED 2009).

People with bulimia may have had one or several suicide attempts and there is a high incidence of depression amongst bulimia sufferers (Eating Disorders Victoria 2010b).

Binge Eating Disorder

Binge Eating Disorder is a psychological illness involving frequently eating excessive amounts of food, often when not hungry. Binges represent a distraction that allows an individual to avoid thinking about the cause of their problems. Feelings of guilt, disgust and depression often follow an episode of bingeing (Eating Disorders Victoria 2009c).

Following a binge the feelings associated with Binge Eating Disorder may be intense guilt, shame and self-hatred. Binge Eating Disorder does not involve purging however a person experiencing the Disorder will often participate in sporadic fasts and repetitive diets in response to the negative sensations which follow a binge episode (Eating Disorders Victoria 2009c).

Binge Eating Disorder can affect anybody, regardless of age, gender or ethnicity. In fact, research suggests equal percentages of males and females experience Binge Eating Disorder (Eating Disorders Victoria 2009c).

The prevalence of Binge Eating Disorder in the general population is estimated to be 4%; a study of 15,000 18-22 year old Australian women found that 20% had symptoms of Binge Eating Disorder (CEED 2009).

Psychotic Disorders

There are a number of psychotic disorders within mental health. Individuals who experience these disorders may lose touch with reality and lose touch with their ability to make sense of their own thoughts, feelings and external information (Department of Health 2009). Types of psychotic disorders include:

- Schizophrenia (psychotic illness has been continuing for at least 6 months)
- Schizophreniform disorder (psychotic illness has been continuing for less than 6 months)
- Schizoaffective disorder (co-occurring symptoms of psychosis and a mood disorder, such as depression or bipolar disorder)
- Delusional disorder (having one or more delusional beliefs)
- Brief (or acute or transient) psychotic disorder (psychotic symptoms develop suddenly in response to major stress)
- Psychotic disorder Not Otherwise Specified (NOS)
- Schizotypal disorder (Headspace 2011).

During a psychotic episode people can perceive their world to be different from normal; however what they are experiencing is real to them (Department of Health 2009). People with psychoses may develop delusions including beliefs of persecution and guilt or they may experience hallucinations where they may see/hear/smell/taste or feel things that are not present in the real world (Department of Health 2009).

Depending on the severity of these cases, the treatment of the disorder can change for each individual. Effective medication and support from mental health professionals assist people who are experiencing a psychotic disorder in their ability to lead a productive and satisfying lifestyle (Department of Health 2009).

Some individuals may experience a brief form of psychosis lasting a few days or weeks. Some people may experience only a few episodes of psychosis during their life. About 3 in 100 people will experience psychosis at some time in their lives; with initial incidence occurring during late teens and early twenties (SANE Australia 2010c).

Schizophrenia

A person with schizophrenia may experience changes in their behaviour and perception and have disordered thinking that may distort their sense of reality; this may also be referred to as psychosis (Department of Health & Ageing 2007b).

The causes of schizophrenia are not completely understood. They are likely to be a combination of hereditary and environmental factors. It is probable that some individuals are born with a predisposition to develop this illness, and that circumstances, such as stress or use of drugs may trigger their first episode (SANE Australia 2010b).

Schizophrenia affects the normal functioning of the brain, interfering with a person's ability to think, feel and act. Some people do recover completely, and with time most find that their symptoms improve. However for many individuals it is a prolonged illness (SANE Australia 2010b).

About 1 in 100 people will develop schizophrenia in their lifetime; incidence usually occurs during late teens and early twenties (SANE Australia 2010b).

Personality Disorders

Personality disorders are names given to explain and categorise patterns of thought, behaviours and feelings. Personality disorders usually cause a great deal of distress to the individual and those around them because they affect a person's ability to function normally. These problems may affect the individual's work, socialisation and relationships with others (Department of Health & Ageing 2007c).

A personality disorder occurs when an individual's thinking pattern and behaviour is extreme, inflexible and maladaptive (Department of Health & Ageing 2007c). Having a personality disorders does not mean that every part of the person's life is negative, or unhappy, just that their thoughts, feelings and behaviours may influence the way they think, feel and experience things (University of Melbourne 2011).

There are 10 personality disorders which are listed below.

1. **Paranoid** – people with this personality disorder are extremely mistrustful and suspicious of people without reason. They do not confide in anyone and expect others to do harm to them.
2. **Schizoid** – people show a limited range of emotions and seem detached from social relationships. Other people may find them cold and indifferent as they do not allow people to get close to them.
3. **Schizotypal** – people who seem to have suspicious or odd beliefs about the world and those around them. They tend to isolate themselves and behave in ways that seem unusual to others.
4. **Antisocial** – people who experience this type of personality disorder often fail to comply with social norms. They may perform actions that others would find inappropriate, such as stealing. There is also a possibility for people to be irresponsible, impulsive and deceitful and they may be viewed as self-centred and manipulative.
5. **Borderline** – people with borderline personality disorder lack stability in moods and relationships. They often have poor self-esteem. These individuals may experience feelings of emptiness and are at a great risk of suicide.
6. **Histrionic** – people with this disorder as often seen as 'actors' and may be overly dramatic in most things they do and with the people they associate with.
7. **Narcissistic** - Individuals who experience this personality disorder consider themselves different from others and deserving of special treatment. They think highly of themselves, which is usually beyond their real abilities.
8. **Avoidant** – People who have avoidant personality disorder are excessively sensitive to the opinions of other people, and as a result avoid social relationships. They usually have low self-esteem and a fear of rejection, which causes them to reject the attention most other people desire.
9. **Dependent** – Individuals with this personality disorder rely on others to let them make decisions for them, from everyday decisions to major ones. This is often the result of fear of being abandoned, which is usually unreasonable.

10. **Obsessive-compulsive** – People have an addiction to things being done perfectly or 'the right way'. This preoccupation usually prevents them from completing most things (Department of Health & Ageing 2007c).

It is important to note that obsessive-compulsive personality disorder differs from obsessive-compulsive disorder, which is an anxiety disorder. The obsessive thoughts and compulsive behaviours are not the same as in obsessive-compulsive disorder (University of Melbourne 2011).

Common Symptoms/Behaviours associated with Mental Illness

Self-Harm

Self-harm (also known as deliberate self-harm, intentional self-harm or self-injury) refers to an act of deliberately inflicting physical harm on oneself, usually in secret and often without anyone else knowing (WHV 2009). Self-harm is recognised as a form of behaviour, distinct from suicide (Mendoza & Rosenberg 2010). Some examples of this include; cutting, burning, biting or hitting the body, pulling out hair or scratching and picking at sores on the skin, binge-eating or starvation, or repeatedly putting oneself in dangerous situations (WHV 2009; SANE Australia 2010d).

Engaging in self-harm does not necessarily mean that someone wants to die; instead it is a behaviour that is used to cope with difficult or painful feelings. Individuals who self-harm report that inducing physical pain alleviates emotional pain (WHV 2009). It may be distinguishable when self-harming behaviour occurs when the intention is to cause injury and when the intention is to cause death (Mendoza & Rosenberg 2010).

Self-harm is closely linked with mental illnesses including personality disorders, depression, bipolar disorder and psychotic disorders (WHV 2009). The following are risk factors associated with self-harm:

- Mental illness.
- Traumatic life events such as neglect and abuse.
- Social isolation.
- Experiencing violence.
- A family history of suicide or suicidal behaviour.
- Low education level (Mendoza & Rosenberg 2010).

Research suggests that teenagers who experience family violence or report having trouble at home (such as parent abandonment or conflict with parents), have an increased risk of self-harm (WHV 2009).

Young women aged 15-19 are 3 times more likely to be admitted to hospital for self-harming than males and are more likely to attempt suicide (Berry & Harrison 2007). Episodes of self-harm are a risk factor for further self-harm and attempted and completed suicide (Mendoza & Rosenberg 2010).

Women make up approximately 62% of reported cases of intentional self-harm and attempted suicide (Department of Health 2010). However this figure may not truly represent the data as many cases do not get reported as some women face social stigma which stems from the common belief that this behaviour is a form of attention seeking, therefore inhibiting them to seek support (WHV 2009).

Suicidality

Suicidality encompasses suicidal ideation (serious thoughts of killing oneself), suicide plans and suicide attempts. Individuals who experience this are at increased risk of attempting suicide (Slade et al. 2009).

Suicide refers to the act of deliberately taking one's own life and is highly connected to mental health and wellbeing (Mendoza & Rosenberg 2010). The reasons why people commit suicide are multifaceted and complex. Suicide can occur due to difficulties in coping with the day to day pressures of life (Bristol 2010). Suicide is the main cause of premature death among people with a mental illness (SANE Australia 2010e). Around 65% of people who die by suicide have symptoms of major depression at the time of their death (Mendoza & Rosenberg 2010). Almost 1 in 10 (8.6%) individuals who have been suffering a mental illness for greater than 12 month's reports being suicidal in the past year. About 10% of people who have a mental illness die by suicide within the first 10 years of diagnosis (Slade et al. 2009).

During their lifetime, 13% of Australians aged 16-85 years will experience suicidal ideation; this is equivalent to over 2.1 million Australians who have thoughts about taking their own life (Slade et al. 2009).

Approximately 2,200 Australians take their own lives each year (Department of Health & Ageing 2010). For every person who dies by suicide it is estimated that there are at least another 30 people who attempt suicide (SANE Australia 2010e). In Victoria, male suicide rates are 4 times higher than female rates however this only represents the number of completed suicides and does not represent suicide attempts. Women attempt suicide more frequently than men but are less likely to follow through with it (Patel 2005). This may be due to women choosing non violent methods such as self poisoning (70%) which is thought to be less effective (WHV 2009). Suicide is the leading cause of death for women aged under 34 years (Mendoza & Rosenberg 2010).

Suicide and attempted suicide rates are higher in women who have been the victim of violence. Women who have experienced violence are 5 times more likely to attempt suicide than those who have not experienced violence (WHV 2009).

Suicide prevention is a major mental health issue among younger and middle-aged women; with women in these age groups reporting suicide-related thoughts and behaviours (Women's Health Australia 2005). The 2007 National Survey of Mental Health and Wellbeing found females were more likely than males to be suicidal, with young women aged 16-24 years being the most suicidal (5%). Adolescents with mental health issues report a high level of suicidal thoughts (Mindframe 2009).

Co-morbidity

Co-morbidity refers to the occurrence of more than one type of illness at the same time; including co-occurring mental illnesses or co-occurring mental illness and physical conditions (Slade et al. 2009).

With 1 in 5 Australians (20%) aged between 16-85 years experiencing a mental illness in the previous 12 months; 1 in 4 of these people experienced co-occurring mental illnesses. Women are more likely to suffer from more than one mental illness at a time, which is then linked to increased severity of mental illness and increased disability (Astbury 2001). Depression and anxiety are common co-morbid diagnoses in which women have a higher prevalence (WHO 2005b); 4% of Australian women experience co-occurring depression and anxiety (Slade et al. 2009).

Approximately 17% of women aged 18-60 are affected by depression, anxiety or both. This rate rises to 44% for women with an alcohol or substance abuse disorder and rises to 55% for women with a diagnosis of illicit substance abuse or dependence (Victorian Government 2009).

Depression and anxiety account for 18% of the total non fatal burden for Australian women's health. Depression and anxiety cause a more significant burden of disease for women than for men (AIHW 2010b). Findings from a Victorian Adolescent cohort study revealed 8% of female adolescents had an eating disorder. Close to 50% of those had high levels of depression and anxiety, especially those with bulimia nervosa (Eating Disorders Victoria 2010a).

Mental illnesses are more likely to co-occur among people with a chronic physical condition (28%) (Slade et al. 2009).

A strong association has been found between co-morbidity and suicidality; with a higher level of suicidal thoughts occurring among people with two or more forms of mental illness (Slade et al. 2009).

Appendix 3: Special Population Groups

It is important when addressing women's mental health and wellbeing that diversity is recognised, both social and cultural, as the experience of mental health and wellbeing and its associated outcomes differ between population groups. There is a need to view women's mental health and wellbeing within the context of income capacity, power in relationships, status in the workplace, greater caring responsibilities and experiences of harassment, violence and discrimination.

It is important to understand the needs of particular groups of women such as young women, new mothers, lesbian, bisexual, transgender, intersex and older women (Commonwealth of Australia 2010). For example, an increased prevalence of depressive disorders has been found among young women, women who have recently given birth, and older women in residential care (Commonwealth Department of Health and Aged Care 2000).

It is also important to recognise that women may belong to more than one population group (e.g. an older woman who is also a lesbian). Women who fit into more than one special population groups may be more at risk of having poorer mental health and wellbeing however they still have the ability and opportunity to achieve positive mental health and wellbeing (Department of Health 2010).

Young Women (aged 15-24 years)

There has been much research exploring mental health and wellbeing among young women; more so than other population groups. Mental health issues are a particular concern for young women; with over half (51%) of the estimated burden of disease in young women due to mental illness (AIHW 2010a).

Findings demonstrate that over 22% of young women report high to very high psychological distress, almost twice the rate of males (ABS 2006a). Nearly a third of the burden of disease for this age group is due to anxiety and depression (Begg et al. 2007). Over the past 10 years, self-harm requiring hospitalisation among young women increased by 51% (Eldridge 2008).

It is in this life stage where young women can undertake risky behaviours such as drug use or unsafe sexual experiences (AIHW 2008). ABS data from 2007 confirm that many young people experience mental illness. An estimated 1 in 4 young people aged 16–24 years (26%; 671,100) indicated they had previously experienced a mental illness—a higher proportion than any other age group. In 2007, 30% of females aged 16–24 years had experienced a mental illness (Slade et al. 2009).

Mental illnesses are the leading contributor to the burden of disease and injury (49%) among young Australians, with anxiety and depression being the leading specific cause for both males and females (AIHW 2007). These mental health issues can affect this population group as a whole however specific groups such as indigenous young women and those from a low socioeconomic group or region may be more at risk (AIHW 2007).

The most common mental health issues for young women are depression, anxiety and substance abuse (AIHW 2007).The link between illicit drug use and mental health is a major concern for young women in Australia as 60% report that they have used drugs (AIHW 2007). In Australia, most (7 out of 10) of the deaths attributed to a mental or behavioural disorder among young people aged 12–24 years were due to abuse of psychoactive substances such as heroin and other drugs (AIHW 2007). Young women who use illicit drugs have an increased risk of mental health issues (WHV 2009).

For young people, self harm and suicidality are a risk factor for mental health issues (AIHW 2008). Research has found over 7,800 hospital admissions for intentional self-harm among young people aged 12–24 years; of these, 71% were for females (AIHW 2008).

The frequency of unwanted sexual activity is another concern for young women's mental health and wellbeing. A Latrobe University study found that 38% of young women had sexual experiences when they did not want to; this number had significantly increased over the research period (Smith et al. 2009). "Being too drunk" and pressure from partners were stated as being the common reasons reported for unwanted sex. Around 20% of young women indicated that they were either drunk or high the last time they had sex (Smith et al. 2009). Unwanted sexual activity may be associated with partner violence. Young women who have experienced any type of partner violence are more likely to have had their first sexual experience at a younger age (Taft, Watson & Lee 2004).

Young women between the ages of 15 and 22 years are much more likely to have negative body image, or body image dissatisfaction. This has been linked to a range of physical and psychological health concerns and risk-taking behaviours, including the development of eating disorders (which are 10 times more common among women than men), low self-esteem, depression, self-harm and suicide (Farmer, Treasure & Szmukler 1986; VicHealth 2004a).

The highest rates of mental illness occur among the 18-24 year age group (Mindframe 2009); with depression being one of the most common mental health problems (Sawyer et al 2001).

One in ten adolescents aged 16-24 years will experience both a mental health issue and a substance use issue (alcohol and/or illicit drug) (ABS 2008a).

Three in four young people with a mental health issue do not access professional help (Andrews, Henderson & Hall 2001; Pitman 2004). Adolescents may be reluctant to access support for mental health issues due to a perception that mental health services are not 'young-people' focussed (Commonwealth of Australia 2009a).

Adult Women

Adult women may be faced with multiple stressors including working, responsibilities at home and social roles (WHIN 2004). Anxiety and depression is a leading burden of disease for adult women (ABS 2006a; Begg et al. 2007). 1 in 5 Australians aged 25–64 years (21% or 2.3 million) had experienced an anxiety, affective or substance use disorder in 2007 (Slade et al. 2009). Anxiety disorders (such as post-traumatic stress disorder) and affective disorders (such as depression and bipolar affective disorder) were more common among females.

Major life changes such as divorce, involuntary unemployment, retirement, becoming grandparents, illness or disability, caring or bereavement may contribute to these higher rates (Commonwealth of Australia 2010).

For most people, the mental illness they experience in adult life has its onset in childhood or adolescence. The ABS (2007) found that, of those in the 16-85 age range who will experience an anxiety or affective disorder, two thirds will have had their first episode by the time they are 21 years of age (Commonwealth of Australia 2009b).

Older Women

In 2008–09, more than 25% of mental health related encounters to GP's were for people aged 65 years and over (AIHW 2010d).

The main causes of poor mental health among women 65 years and over is anxiety, tension, fatigue or anger; as well as a lack of social activity and interaction (AIHW 2010b). Mood (affective) disorders, such as depression, were the most common type of mental health issue reported by older people (AIHW 2010a).

Women as Carers

A woman's role as primary carer can also have a significant impact on their mental health and wellbeing. Women's major role in caring for both children and older parents can have negative impacts on their own mental health. Women often act as carers for others experiencing mental illness, and as such, the increased burden of care of relatives has a much greater impact on women (Commonwealth of Australia 2010).

There are over 2.9 million Australians providing care for family members or friends with a mental illness. The carer provides the main sense of support and 70% of primary carers are women (Carers Victoria 2011a). Within the caring population, female carers in particular experience much lower levels of mental health compared to both male carers and the general population. This includes increased levels of clinical depression, with over 50% of female carers reporting being depressed for six months or more since they began caring (Edwards et al. 2008).

Women may feel social pressures to take on a caring role such as an expectation of looking after a partner, parent, child, sibling, grandparent or friend; they may experience social isolation; a decreased ability to participate economically within the community; and a lack of recognition of the significance of their role, all pressures which may have a detrimental effect on the carer's own mental health (WHIN 2004).

Caring can be emotionally taxing and physically draining. Carers have the lowest wellbeing of any large group measured by the Australian Unity Wellbeing index. Carers often ignore their own health and wellbeing needs and are 40% more likely to suffer from a chronic health condition. Some health problems, such as back problems, anxiety and depression, can be directly linked to caring. Many carers are chronically tired and desperately need to refresh through a night of unbroken sleep, a day off or an extended period with no caring responsibilities (Carers Victoria 2011b).

Many carers feel isolated, missing the social opportunities associated with work, recreation and leisure activities. The demands of caring can leave little time for other family members or friends. Carers often have to deal with strong emotions, like anger, guilt, grief and distress that can spill into other relationships and cause conflict and frustration (Carers Victoria 2011b).

Women who live in Rural, Regional and Remote Areas

Mental health issues experienced by women living in rural, regional or remote areas are similar to those experienced by all women; however the issues may be heightened due to geographical location. Some of the issues identified by women living in rural, regional and remote areas include:

- Anxiety.
- Depression.
- Social isolation.
- Violence against women.
- Lack of access to appropriate services.
- Unstable environmental conditions.
- Financial insecurity.

A high proportion of these women have trouble accessing appropriate services and support due to the limited availability of services (WHV 2009). Affective and anxiety disorders have been identified at higher rates among females in rural and remote areas than males (AIHW 2010a).

Women who have concerns about their health may be less inclined to discuss it with their health care provider due to the close-knit structure of rural and remote communities; it may be difficult to ensure privacy as service providers are often members of the same community. Issues also arise for women who have concerns about the provision of care that they receive; it may also be difficult to raise concerns or complaints about the provision of services due to limited alternatives (WHV 2009).

Mental health issues or illnesses can deteriorate in rural communities due to:

- Waiting lists.
- Lack of treatment options.
- The need to travel long distances to access health care services (Response Ability 2008).

Women with Disabilities

Approximately 20% of Australian women have a disability (WHV 2009; ABS 2005). Within Australia, disability is defined as a condition that in some way hampers or hinders a person in terms of their ability to carry out day to day activities. The extent to which a condition hinders a person will vary from individual to individual (Commonwealth of Australia 2005).

Women with disabilities can be exposed to many forms of discrimination due to their gender and disability (WHV 2009). Discrimination may lead to mental health issues such as social exclusion, violence and poor self esteem (WHV 2009). Some examples of this are:

- More than half of people aged 16–64 years with severe or profound disability had symptoms of a mental illness; with a high proportion reporting that they had seriously considered suicide in the previous 12 months (AIHW 2010a).
- Fifty-five percent of women with disabilities report mental health problems such as a dual disability and many suffer from poor self-esteem caused by social exclusion (WHV 2009; Salthouse 2004).
- Women with disabilities are more vulnerable to experience violence (Better Health Channel 2009).
- Women with a disability, related to trauma, have been found to be at higher risk of depression than women without a disability as a result of trauma (McDermott et al. 2007).

The discrimination that can stem from having a disability can also reduce the limitations for employment opportunities which can force a woman with a disability to rely solely on the pension as a primary source of income (WHV 2009). There are around 29,000 women with disabilities that have median gross personal incomes of less than $200 per week, and only 32% of women with disabilities earn income through employment (WHV 2009; ABS 2005). Those who find employment are more likely to be employed in low status and low paid jobs, being exposed to poor working conditions (WHV 2009). Insufficient access to economic resources causes immense stress as it may lead to poverty and poor living conditions (WHV 2009).

New Mothers

Women going through the life transition of becoming a mother may experience mental health issues. Between 13-25% of women experience emotional distress including depression and anxiety during the perinatal period (Perinatal period – commencement of pregnancy to one year after birth) (Department of Health 2010). This has a profound effect on their own health and wellbeing, and on their children and families. Good maternal mental health in the perinatal period impacts positively on the cognitive, emotional and behavioural consequences of children (Buist & Bilszta 2006).

Pregnancy and the postnatal period (4 to 6 weeks after delivery) is a time of vulnerability to poor mental health. Anxiety and depressive symptoms are common during and following pregnancy, with the highest rates in the second and third trimester (Bennett et al. 2004). The postnatal period is a time of risk for onset of new mental illness, postnatal depression and relapse in women with established depressive disorders (Cohen et al. 2006a; Cohen et al. 2006b). High quality care for women is needed before, during and after birth, particularly for those with existing mental illness.

Single Mothers

In Australia, 1 in 5 families with children under the age of 15, is headed by a single parent with the overwhelming majority (87%) of these families being headed by a single mother (PRC 2009).

The financial strain on single mother families can impact on the mental health and wellbeing of both themselves and their children. Single parented families have approximately 30% less disposable income than coupled families (PRC 2009). Single parent families are more than likely to be living in rental housing and are frequently surviving on low incomes under the poverty line (PRC 2009).

Women from Aboriginal and Torres Strait Islander (ATSI) backgrounds

Aboriginal and Torres Strait Islander women make up 2% of all Australian women and 1% of Victorian women (WHV 2009).

Aboriginal and Torres Strait Islander women are at an increased risk of experiencing family violence and sexual assault, further impacting their mental health status. Indigenous women are almost 10 times more likely to die from assault than non-Indigenous women and are 35 times more likely to be admitted to hospital as a result of family violence (WHV 2009).

Colonisation of Indigenous Australians has had an immense effect on their mental health and wellbeing. Some of the factors that are associated with this include:

- Loss of land.
- Loss of spiritual and cultural traditions.
- Loss of lives through massacres and epidemics.
- Removal of children from their families.
- Ongoing racism, social exclusion and poverty (WHV 2009).

There are also higher levels of morbidity and mortality due to mental illness compared to non-Indigenous women and they are hospitalised for mental health issues at a rate of 1.6 times higher than non-Indigenous women (WHV 2009). Aboriginal and Torres Strait Islanders have poorer social and emotional wellbeing than non-Indigenous Australians; in 2006–07 the rate of community mental health service contacts for Indigenous Australians was 2.5 times that for other Australians (AIHW 2009).

Women from Culturally and Linguistically Diverse (CALD) backgrounds

Culturally and linguistically diverse (CALD) women are those who speak English as a second language (first language is not English) and/or who were born in a country other than Australia (WCHM 2010). These women have migrated to Australia or may be refugees or asylum seekers (WCHM 2010).

In Victoria there are approximately 2.5 million women of which 25% speak languages other than English at home (WHV 2009). In Victoria, women from CALD backgrounds comprise 19% of the total female population (ABS 2006c). The most diverse LGAs in the EMR in terms of the birthplace countries of females are Manningham, Monash and Whitehorse. One-third (33.9%) of females in Monash were born overseas in countries that are (mainly) NES. Meanwhile, just over one-quarter (28.5%) of females in Manningham and just under one-quarter (22.9%) of females in Whitehorse were born overseas in NES countries (Women's Health East 2010).

Women from CALD backgrounds can be vulnerable to social isolation, poor access to economic participation, discrimination and violence which may place them at risk of having poor mental health (WHV 2009). This is not as a result of biological dispositions towards poorer health, but as a result of the social and economic conditions in which these women are living (WHM 2010b). For CALD women who have a limited knowledge of English, language barriers and a limited support network can make it difficult to seek help for mental health conditions and violence.

Women from CALD backgrounds who give birth have been found to be at higher risk than other women of post-natal depression, particularly if they have migrated to an English-speaking country (Pal & Wright 2003).

Women from CALD backgrounds do not access mental health services as readily as non-CALD Australians (Mindframe 2009). In addition to this, people from CALD backgrounds may describe their symptoms in terms of physicals problems rather than low moods or negative thoughts which can make detection more difficult (WHV 2009).

Women who are Same-Sex Attracted

High rates of depression, anxiety, suicide attempt and suicide completion can be found in lesbian, gay, bisexual and transgender communities (McNair, Anderson & Mitchell 2001). Same-sex attracted women experience a lower sense of belonging than heterosexual women (McLaren 2006).

Discrimination and violence are major concerns for same-sex attracted women. Research findings suggest 34% of same-sex attracted women report having been socially excluded or ignored, 9% report having been refused employment or promotion and 3% have been refused housing due to their sexual orientation (Pitts et al. 2006). These acts of discrimination make many same-sex attracted women reluctant to reveal their sexuality, with around 33% of women reporting that they either generally or always avoid disclosing (Pitts et al. 2006). Discrimination can also lead to violence; 56% of same-sex attracted women report having been verbally abused, 15% having received threats of violence and intimidation, while 7% have been physically attacked (Pitts et al. 2006).

Approximately 38% of same-sex attracted women in Australia suffer from depression and 62% have visited a counsellor or a psychiatrist in the past five years (Pitts et al. 2006). Poor mental health can increase risk-taking behaviours and same-sex attracted women report higher use of alcohol and drugs than heterosexual women including risky alcohol use (7% and 4% respectively), marijuana use (59% and 22% respectively) and illicit drug use (41% and 10% respectively) (Hillier, De Visser & Kavanagh 2003).

Social inclusion and supportive networks play an important role in cultivating positive mental health and wellbeing outcomes for women who are same-sex attracted. Women who are 'out', who have their sexuality accepted by their family and friends, and/or are part of the gay and lesbian community report more positive mental health compared to same-sex attracted women who do not experience social acceptance (Morris, Waldo & Rothblum 2001).

Evidence also suggests that bisexual women are more likely to suffer poorer mental health outcomes compared to lesbians and heterosexual women. This may be due to the difficulty faced by bisexual women in being accepted into heterosexual or lesbian communities (Rothblum & Factor 2001).

For a full list of references, please refer to the main body of the Women's Mental Health and Wellbeing Overview Document (WHE 2012).