

# ***Stress, Oppression & Women's Mental Health: A Discussion of the Health Consequences of Injustice***

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*Oppression results in persistent and intersecting impacts on women's health, including their spiritual, psychological and biophysical health. Although the concepts of oppression and stress have been discussed extensively in the literature, there is relatively little discussion of the complex interplay among the body's biophysical stress handling systems and the everyday impacts of oppression. This article focuses on the root causes of women's mental health struggles, with emphasis on the nature and impacts of intersecting oppressions and the social determinants of health. Violence against women is highlighted as a key foundation for women's stress across the lifecourse. Oppression has a profound and long-lasting impact on the body's stress handling system. These pathways are detailed with a focus on mental health and biophysical health consequences of oppression. The article concludes with a discussion of the new drivers of medicalization, and psychiatrization in particular, in the context of oppression and women's mental health.*

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Although the concept of women's oppression has been extensively discussed in the literature, there continues to be a need for further exploration of the ways that oppression is inscribed on women's bodies, minds, and spirits over time and intergenerationally. When women experience the mental stress of oppressions such as racism, misogyny, and ageism, and the unjust policies that create and sustain poverty, they are impacted persistently over time. Using an intersectionality lens, this paper describes some of the most important root causes of women's mental health struggles. The social determinants of women's health (SDH) are discussed from a critical perspective that locates women's mental health within the context of oppressive societal structures.

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Violence against women, a key SDH, is discussed in detail. These discussions lay the foundation for a reframing of “vulnerable women” (i.e. individually vulnerable to mental diseases) to “women under threat” (i.e. impacted by oppression). This paper also makes a contribution to the literature regarding the pathways between the stresses of oppression, and resultant mental and physical health outcomes for women and their families. In particular, the discourse of psychiatrization is targeted for its key role in creating and sustaining women's oppression.

### ***Root Causes of Women's Mental Health Struggles***

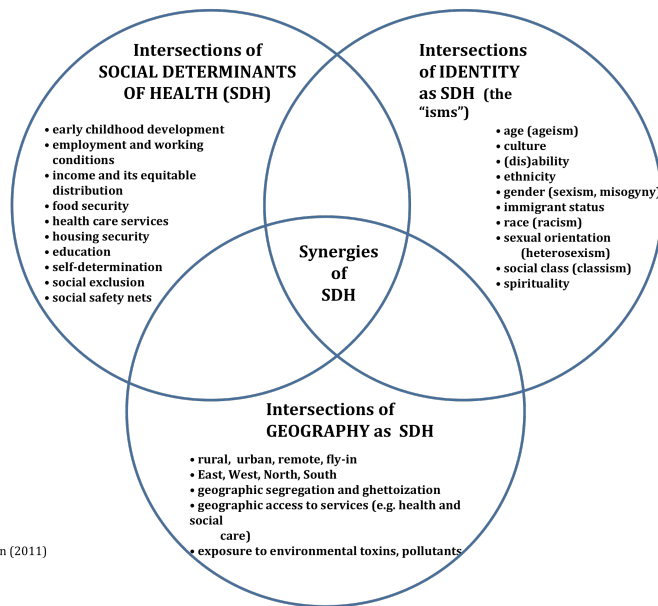
Critical perspectives, particularly in the area of the SDH, have illuminated the root causes of compromised health outcomes—the causes-of-the-causes. Public policy approaches, particularly the neoliberal ideologies, continue to shift the locus of responsibility from the state (i.e. maintenance of strong social safety nets) to the realm of the individual or family unit (Raphael, 2012). The primary onus for solution is thus placed on the women themselves, rather than on collective societal efforts to look after the most vulnerable among us. As the following discussion emphasizes, intersections of inequities in the SDH are of central importance in understanding these root causes.

### ***Oppression & the Social Determinants of Women's Mental Health***

The social determinants of women's mental health are foundational to understanding the pathways that create mental health struggles. These persistent inequities create ongoing, significant disadvantage and material deprivation for women oppressions related to SDH, including mental health, are powerful predictors of health and social outcomes across the lifecourse. There has been extensive work in the study of the SDH (Raphael, 2009; Raphael, 2012; World Health Organization (WHO), 2008 and their application has expanded to include the ‘isms’ as SDH and geography as an SDH (McGibbon, 2009; McPherson & McGibbon, 2010; McPherson & McGibbon, 2013, In Press). According to McGibbon and McPherson (2011), although feminist intersectionality theory greatly enriches our understanding the health impacts of oppression, it falls somewhat short when one considers how the ‘isms’, the SDHs, and the spatial contexts of oppression, all combine in a deadly synergy for oppressed peoples. “Here, synergy implies working together, fusion, coalescence, and symbiosis—the parts interacting to form a complex whole that cannot be disentangled into any single phenomenon” (McGibbon & McPherson, 2011, p. 61). Figure 1 illustrates how The SDH (Toronto Charter, 2003) the ‘isms’ as SDH, and geography as an SDH, may interact in this synergistic manner. The

following discussion outlines some of the mental health impacts of these intersections and their related oppressions.

**Figure 1: INTERSECTIONS of the SOCIAL DETERMINANTS of MENTAL HEALTH**



Source: Adapted from McGibbon, E. & McPherson (2011)

Poverty is the strongest determinant of women's health and there is a deepening of the racialization and feminization of poverty in Canada: "While poverty, inequality and a deteriorating quality of life are worsening in Canada, the depth of poverty is most particularly experienced by women" (Wallis & Kwok, 2008, p. 12). The impacts of long term, persistent stress related to the SDH, the *isms*, and geography are central to women's mental health struggles. Senior women are particularly impacted by poverty in Canada and in other countries. In the United States, older women are at greater risk of economic insecurity than older men: 60% of women age 65 and older who live alone or live with a spouse have incomes insufficient to cover basic, daily expenses. By contrast, 41% of older men studied live in households that have incomes that fall short of economic security (Wider Opportunities for Women, 2012). In Canada, the poverty rate for senior women is 19.3%, while that for senior men is 9.5% (Statistics Canada, 2012). Almost half (41.5%) of unattached (single, widowed or divorced) women over 65 are poor. Unattached women are singularly impacted by poverty:

*Women on their own are the poorest of the poor, especially women raising children in lone-parent families, who are almost five times more likely to be poor than those in two-parent families. Yet their plight has been virtually ignored by the policy-makers. Older women on their own are also 13 times more likely to be poor than seniors living in families, with more than 14% of them having had low incomes in 2007. That these two groups of women had such high rates of poverty, at a time when poverty rates for others had dropped to relatively low levels, must surely be a cause for serious concern." (Townson, 2009)*

Age, race, gender and im/migration status (ageism, racism, sexism, misogyny) all intersect to create even greater poverty for many women. Aboriginal women, regardless of age, earn significantly less than the Canadian women's average wage. In 2005, the median income of Aboriginal women was \$15,654, about \$5,000 less than the figure for non-Aboriginal women, who had a median income of \$20,640 that year. The median income of Aboriginal women was also about \$3,000 less than that of Aboriginal men, for whom the figure was \$18,714 (Statistics Canada, 2012). Most immigrant and refugee women are women of color. In 2005, immigrant women of all ages were more likely to be living in a low-income situation than Canadian-born women. Among the immigrant girls and women in an economic family, 20% lived below Statistics Canada's low income cut-off before tax, compared with 10% of the Canadian-born girls and women. The overall poverty rate for foreign-born women is 23%, rising to 35% for those who arrived between 1991 and 2000 (Statistics Canada, 2012).

The profound mental health impacts of persistent policy-created poverty are increasingly being recognized:

*People in lower socio-economic classes by virtue of their life circumstances are exposed to more stressors, and with fewer resources to manage them and greater vulnerability to stressors, they are doubly victimized (Murali & Oyebode, 2004, p. 216).*

Housing and heat insecurity go hand-in-hand with women's poverty. One of the most distressing aspects of being poor is women's financial incapacity to provide basic human needs for their families. Low income households, and communities of color, are disproportionately located in areas with significant noise and air pollution (Saylor, 2011), thus creating serious health problems for women and their families. Heat insecurity has an impact on a growing number of households because poverty has placed these families in a "heat or eat" crisis. In the United States, the National Energy Assistance Directors' Association (NEADA,

2008) completed its first national survey of utility averages and utility shut-offs in 2008. Based on a sample of eleven states representing 25 percent of all households, an estimated 1.2 million households were disconnected from electric and natural gas service from March through May, following the expiration of state shut-off moratoria.

Food insecurity is a direct result of poverty. It has been shown to be particularly germane to the lives of women and their families in the context of their global contribution to food production and preparation and the increasing number of female-headed households worldwide (Ivers & Cullen, 2011). Women are the most at risk for food insecurity since they live with disproportionately high levels of poverty, especially marginalized and racialized women. The mental health impacts of food insecurity are profound for women and their children, yet there is relatively little investigation of the complex relationships among poverty, food insecurity and mental health struggles. "Food insecurity is associated with obesity, anxiety, and depressive symptoms; risky sexual behavior; poor coping strategies; and negative pregnancy outcomes in women, although evidence about the direction and causality of associations is unclear" (p. 1740S). Since the 1980s the number of Canadians affected by food insecurity has steadily grown. In a study of food insecurity and hunger among 141 low-income lone mothers with children in Atlantic Canada, 96.5 percent experienced food insecurity over the previous year (McIntyre, Glanville, Officer, et al., 2002).

These poverty-related deprivations create persistent stress for women and poverty is deepened when oppressions intersect. For example, women with disabilities are disproportionately subjected to inadequate health and social care services such as transportation, rehabilitation, support, and assistance. Due to their gender and their disability, women have a high chance of facing "double discrimination" (United States AID, 2013): Women with disabilities are much more likely to experience various forms of material hardship— including food insecurity, not getting needed medical or dental care, and not being able to pay rent, mortgage, and utility bills— than people without disabilities, even after controlling for income and other characteristics (Fremstad, 2009). Disability, gender and rural location all intersect to create a distressing impact on the health of women with disabilities. A common negative health outcome of disability is depression, which has an effect on multiple aspects of women's lives, such as physical health, employment, quality of life, and mortality (Hassounah, Nguyen, Chen, & McNeff, 2013). In a US study of depression in rural women with physical disabilities, 75% of participants reported moderate to severe depression, with almost 20% having thoughts of suicide (Hughes, Nosek, & Robinson-Whelen, 2007). Even more troubling is the fact that more than

one-third of the women involved in the study had not received treatment for their depression (Hughes, Nosek, & Robinson-Whelen, 2007).

Considerable qualitative and quantitative evidence indicates, that intersections of the SDH have a powerful influence on mental health outcomes. Rural geography intersects with gender to amplify women's mental health struggles. Low income rural women in general are much more likely to report feeling depressed than urban women (Simmons, Huddleston-Casas & Berry, 2007).

Urban and rural Black women are more likely to report feeling depressed, and rural Black women are even more likely to experience depression, especially young Black women (Miranda, Siddique & Belin et al., 2005). Depression is experienced by women of all social classes; however, poverty places women at particular risk. In African American women, their gender, race and associated poverty are accurate predictors of depression (Nicolaidis et al., 2010) – or more accurately their exposure to sexism and racism.

Heterosexism has also been linked to depression and other mental health difficulties. Bisexual women and lesbians were far more likely to report higher levels of anxiety, experiences associated with depression, self-injury, and suicide thoughts and attempts, when compared to heterosexual women (Kerr, Santurri, & Peters, 2013). Bostwick, Boyd, Hughes, & Esteban McCabe (2010) found disparities in the mental health of lesbian and bisexual women when compared to heterosexual women. Almost 60% of bisexual women had experienced depression in their lifetime, compared with 44.4% of lesbian women, 36.5% of women who were not certain of their sexual identity, and 30.5% of heterosexual women. These statistics, when combined with SDH such as poverty, disability, rurality and racism, create a clear picture of the mental health impacts of oppression.

***Violence against Women: A Key Social Determinant of Health***

Violence and human rights violations against women and children are one of the most widespread and significant global public health problems (United Nations Women, 2013). In all societies, women are exposed to sexual, physical, emotional, and economic violence, regardless of their income, class, or culture (United Nations Department of Economic and Social Affairs, 2010). Researchers have consistently found intimate partner violence to be the most common form of violence that women experience worldwide, with men most often being the perpetrator (Sinha, 2013; WHO, 2013). A multi-country study of 24,000 women found that between 15% and 71% of women have experienced physical and/or sexual violence by an intimate partner in their lifetime, with most areas ranging from 30% to 60% (WHO, 2005). Regardless of whether families are living in relative poverty, women and children experience violence in their homes at a disproportionately high rate when compared to men (McGibbon & McPherson, 2011). For instance, in Canada in 2011 the rate of intimate partner violence for females was 542 victims per 100,000 women. The rate of intimate partner violence for males was 139 male victims per 100,000 population (Sinha, 2013). Globally, high rates of intimate partner and sexual violence experienced by women are associated with the unequal position of women relative to men, and the normative use of violence to resolve conflict (WHO, 2013).

Women living in war-torn countries face devastatingly high rates of violence. In modern armed-conflicts, as much as 90% of victims are among civilians, with the majority being women and children (United Nations Women, 2013a). In South Kivu, DRC, 40 women and children on average are raped each day; the estimated total number of women and children raped during the country's decade-long conflict is more than 200,000 (United Nations Women, 2013a). Rape and other acts of sexual violence are used as tactics of war to weaken family ties, destroy communities, as well as to "ethnic cleanse"—a method to change the ethnic make-up of future generations (Mukamana & Brysiewicz, 2008). ). An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters, and displacement are women and children. The high prevalence of sexual violence to which women are subjected has been positively related to the fact that they are the largest single group of people who are suffering from post traumatic stress (WHO, 2006).

Violence against women is endemic across geographies and social classes. The mental health consequences of embedded violence are vast. Misogyny is intimately linked to everyday stress in women's lives and to the traumatic stress of long-term, persistent experiences of emotional, spiritual and physical violence. Women around the world, and across all age groups, have higher rates of depression than men (WHO, 2000a).

Scholars have linked women's depression with unfair distribution of material and financial resources (Belle & Doucet, 2003), family violence, and violence due to war and civic unrest (WHO, 2006). Statistics Canada (2006a) reported that the spousal homicide rate against women was five times higher than the corresponding rate for men. Homicide rates in rural areas were almost identical to rates in urban areas, thus underscoring the comparable vulnerability of rural women. In Canada, spousal violence was the largest category of convictions involving non-specialized adult courts over the five year period 1997 to 2002. Over 90% of offenders were male (Statistics Canada, 2006). Between April 1, 2003 and March 31<sup>st</sup>, 2004, 58,486 women and 36,840 children sought refuge in one of Canada's 473 shelters (Statistics Canada, 2006b). In his book, *The War on Women*, Brian Vallée (2007) revisited the assault of women in their homes:

*From 2000 to the end of 2006, the total of all U.S. military and law enforcement deaths – including accidents and suicides – was 4,588. The combined total of all Canadian military and law enforcement deaths in that period was 101. In that same seven years more than 8,000 women in the U.S. were shot, stabbed, strangled, burned, or beaten to death by the intimate males in their lives. While in Canada, over 500 women – five times more than Canadian soldiers and police officers – were killed by their current or former male partners. Even adding in all the victims of 9/11 to the U.S. law enforcement and military total, it's still less than the number of women killed. (Vallee, p. iv)*

Women who experience sexual, physical, emotional, or economical violence often have wide range of emotions and feelings in response to their long and short term assaults. Researchers and others have consistently documented the serious long term psychological and spiritual impacts of living in an environment of violence, including chronic deregulation of the adrenal system (Goddard, Ball, & Martinez, 2010). Results from the WHO's 2005 multi-country study show that women who are victims of physical or sexual violence, or both, have significantly higher levels of emotional distress than women who have never experienced physical or sexual violence. In addition, female victims were more likely to have had suicidal thoughts, and to have attempted suicide (WHO, 2005).

Globally, during pregnancy, approximately one in four women experience physical and/or sexual violence, thus greatly increasing the risk of birth complications, such as miscarriage, still birth, and spontaneous abortion (United Nations Women, 2013). The results of a study in North Carolina by Martin et al. (2006) indicate that the



prevalence of psychological abuse during pregnancy is much higher, with approximately 85% of respondents experiencing at least one psychologically aggressive act by their intimate partner both during the year before pregnancy and during pregnancy. More than a quarter of women affected by intimate partner violence have reported feeling the need to use medication to help cope with depression, anxiety, or sleep problems experienced as a result of the violence (Sinha, 2013).

**Table 1 Violence: A Social Determinant of Women's Mental Health**

**Global Violence Against Women and Girls**

- Globally, up to six out of every ten women experience physical and/or sexual violence in their lifetime (UN Women, 2013).
- For women between the ages of 15 and 44, acts of violence cause more death and disability than cancer, malaria, traffic accidents and war combined (UN Women, 2013).
- 83% of men are accountable for police-reported violence committed against women (Sinha, 2013).
- In the majority of settings that were included in a multi-country study, over 75% of women physically or sexually abused since the age of 15 reported the perpetrator as being a partner (WHO, 2005).
- "In 2011, eight in ten victims of police-reported intimate partner violence were women" (Sinha, 2013).
- In 2011, Canadian females aged 15 to 24 generally experienced the highest rates of police-reported violence (Sinha, 2013).
- In Canada, between the years 2001 and 2011, Aboriginal women represented "at least 11% of dating homicide victims, and at least 10% of non-intimate partner homicide victims" (Sinha, 2013).
- In the 1994 Rwandan genocide, approximately 250,000 to 500,000 women and children were raped (UN Women, 2013a).
- In South Africa, every 6 hours a woman is killed by an intimate partner (UN Women, 2013).
- A woman is assaulted every 15 seconds in Sao Paulo, Brazil (UN Women, 2013).
- More than half (between 55% and 90%) of women who have been physically abused have never sought help from formal services or from people in positions of authority (WHO, 2005).
- Studies conducted on an international level indicate that about 20% of women and 5-10% of men experienced sexual violence as children (WHO, 2013).
- In Canada in 2011, "approximately 8,200 girls under the age of 12 were victims of violent crime, representing half of all child victims of violent crime" (Sinha, 2013).
- Women are underrepresented in formal peace processes and meetings. Recently, women represented less than 8% of participants and fewer than 3% of signatories, in addition, no woman has ever been appointed chief or lead mediator in UN-sponsored peace talks (UN Women, 2013a).

### ***Women Under Threat***

There are major challenges when considering the pathologizing of women's oppression. As the reader may have gathered, there is an inherent paradox when one is gathering evidence to expose the mental health impacts of oppression: in order to make a case for the impact of oppression, one must consider evidence related to psychiatric diagnostic categories such as depression, anxiety, eating disorders, and so on. These categories play a central role in locating the 'problem' in individual women, rather than in misogynist social systems. The discourse of women's mental health struggles, particularly in the health fields, is largely framed around "vulnerability". Thus, the locus of the problem is most often situated within the individual woman and her family, particularly when women enter the psychiatric system to seek assistance with their struggles.

*The vulnerability discourse implies that an individual or community is somehow more prone to experiencing health inequities, in much the same way as one might be prone to catching a cold. The concept of vulnerability worked well when it first came into common usage because it allowed us to name the people who are most oppressed and thereby attempt to influence public policy in the direction of justice. However, the term is not ultimately effective in ameliorating the physical, spiritual and psychological suffering caused by injustice because it reinforces the idea of a nebulous force that is somehow causing ill health. Rather, it is time to change our thinking to explicitly identify the threats that are causing ill health: colonization, re-colonization, post-colonialism, neoliberal economic policy and corporatization of health care delivery, to name a few. (McGibbon, 2012, p. 33)*

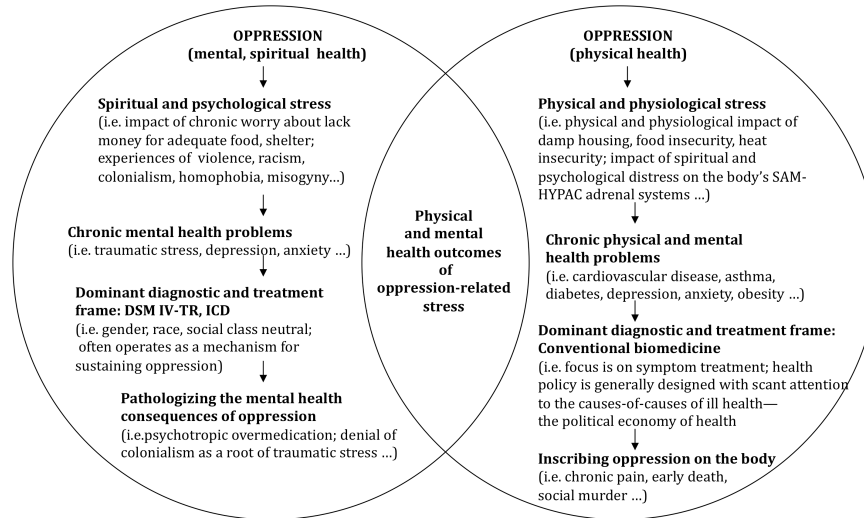
Given the enormous amount of evidence of women's oppression, the vulnerability discourse is more aptly reframed as "women under threat". Our task is to focus on the social pathogens, such as inequities in the SDH, that cause these threats—the root causes of women's mental health struggles.

Ultimately, the mental health outcomes of oppression happen in synergy with physical health outcomes. There has been relatively little attention in the literature, however, to the ways that oppressive societal structures are articulated to these psychological and physiological health pathways. Although there is a substantive field of knowledge about the impact of stress on the body's adrenal system, and the impact of oppression on oppressed groups and peoples, the synthesis of these two areas of knowledge is in its relative infancy. The following section builds

on work in these areas to provide a critical perspective on oppression-related stress.

The intersections of the social determinants of women's mental health (SDH), the '*isms*' as SDH and geography as an SDH, have a profound impact on the body's stress managing systems— the sympathetic adrenal medulla (SAM) and the hypothalamus-pituitary-adrenal cortex (HYPAC), both located near the brain. The SAM-HYPAC system is structured to deal with everyday stresses in addition to more acute stresses. The system regulates our bodies through short-term stressful times and helps us maintain overall wellness. The problem arises when long-term, chronic stresses, such as those described above, eventually overtax the SAM-HYPAC system. The adrenal system becomes overwhelmed and is unable to maintain physiological balance. The result is adrenal fatigue. Chronic adrenal fatigue causes depression, obesity, hypertension, diabetes, cancer, ulcers, chronic stomach problems, allergies and eczema, autoimmune diseases, headaches, kidney and liver disease, and overall reduced immunity (Varcarolis, 2013). These physical and mental health outcomes of adrenal fatigue are embodied in oppressed peoples. They combine with social and material deprivation and discrimination to create consistently unjust health outcomes and an everyday kind of physical and spiritual suffering that has gone unacknowledged for far too long.

As Figure 1, *People Under Threat: Health Outcomes of Oppression-related Stress*, illustrates, it is crucial to note that mental health consequences of women's oppression have at least two pathways. The more recognized pathway involves chronic mental health problems resulting from persistent spiritual and psychological distress. The less acknowledged pathway involves chronic mental health problems resulting from persistent distress on the adrenal system—the body's stress-handling system. When women experience chronic poverty, the cumulative stress of worrying about food, shelter, and a myriad of other deprivations leads to chronic anxiety and sometimes depression. The everyday and relentless nature of this kind of worry is difficult to fathom unless you have personal experiences of these material struggles.

**Figure 2** People Under Threat: Health Outcomes of Oppression-related Stress

Source: McGibbon, E. (2012). Social determinants of mental health: Pathologizing the health outcomes of oppression. Halifax: Fernwood Publishing

The intersecting relationships among the social determinants of health (SDH), the *isms*, and mental health struggles, have led to a growing critique of biomedical, and in particular, psychiatric approaches to assessment and intervention in the area of women's mental health. An individualistic focus obscures attention to the social and economic conditions that cause or exacerbate mental health problems (McGibbon, 2009). Most publicly funded mental health services in Canada use the psychiatric diagnostic categories outlined in the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association, 2004). Although the assessment system in the DSM-IV-TR includes a category entitled 'psychosocial and environmental problems', its brief (1 ½ / 900 pages) description *remained exactly the same* in the 2004 edition as it was in the 1994 edition. Culture, gender, and age features are discussed in terms of epidemiological, rather than sociological, significance (McGibbon, 2009). This token and outdated attention to the influence of the SDH and the *isms* in the development of mental health and wellness is indicative of a much larger problem in the delivery of mental health services in Canada. Consistent historical reliance on the biomedical model of psychiatry, a framework which has limited capacity for incorporating spiritual, economic, and political origins of mental health struggles, has made it next to impossible to develop a mental health system that effectively responds to SDH related stress (McGibbon, 2009).

In the widely-used DSM-IV-TR (American Psychiatric Association, 2004) classification system, depression is described as a psychiatric disorder. Women's depression is categorized as a discrete, apolitical event or process. Despite its title, DSM diagnostic categories are not based in science. Rather, they are created on the basis of international committee consensus and votes, and there are very few women committee members. Since experiences of depression and stress are strongly influenced by the SDH, those experiencing stress related to unemployment and adverse working conditions, racism, inadequate or no housing, and social exclusion are under threat of the medicalization of problems that are in fact, structural, systemic problems. Although a critique of biomedical psychiatry has been historically described in detail elsewhere (for example, see Breggin, 2008, 1991; Caplan, 2004; Illich, 1976; Stoppard, 2000), it is centrally important to underscore the relationship between psychiatrization and oppression.

Here, it is important to focus on what Conrad (2005) terms the shifting engines of medicalization, and psychiatrization in particular. Medicalization has been defined as the rendering of life experiences as processes of health disorders that can be discussed exclusively in medical terms and to which only medical solutions can be applied (Illich, 1976). Behaviours, conditions, and experiences are given a medical meaning with narrowly defined parameters and narrowly prescribed treatments. Psychiatrization is a particular genre of medicalization, and its relationship to the structural determinants of health has received relatively little critical attention within the health fields or even in the social sciences. Although pathologizing the mental health consequences of social injustice has been clearly detailed elsewhere, psychiatrization is not often explicitly identified as a continued mechanism of the apparatus of the modern day oppression of women.

Although many clinicians explore the SDH in the clinical setting, the Canadian diagnostic frame remains rooted in the DSM-IV-TR (American Psychiatric Association, 2004). The international equivalent is the International Classification of Diseases (ICD-10) (WHO, 2007). Both these texts serve as a powerful unifying philosophy that dominates the ways that mental health and illness are framed in the Western world, and increasingly in the global south. Central to this philosophy are beliefs about the individual and apolitical nature of mental illness, the dominance of psychotropic medications as the primary mode of intervention, and the increasing primacy of linkages between the field of psychiatry and the transnational pharmaceutical industry.

The resulting medicalization of oppression causes systemically created social problems to be re-framed as individual psychiatric disorders where clinical treatment continues to heavily rely on psychopharmaceuticals. The efficacy of some psychotropic drugs

notwithstanding, stress and anxiety related to oppressive living conditions cannot be ameliorated with a consistent and primary focus on drugs. Women's poverty is very often central to their experiences of depression. For example, in the case of recovery from the intergenerational trauma, of colonialism, a much deeper and more sophisticated approach is required, an approach that the current psychiatric system is ill-equipped to undertake. Taken together, the above statistics about women's mental health outcomes provide compelling evidence of injustice and how it becomes embedded in the spirit and the psyche. These are the mental health consequences of oppression and they have their origins in the structural determinants of health. Although people can and do develop mental health problems that are not rooted in oppression, it is imperative that policy makers, researchers, practitioners and the general public recognize the disproportionate incidence of mental health struggles in those who experience discrimination and oppression.

In order to move forward, it is necessary to tackle the shifting engines of medicalization, once largely confined to the realm of the medical practitioner. Economic globalization has significantly altered the ways that health is conceived and the ways that the market heavily influences the central drivers of the health system. According to Conrad (2005), the ideological center of medicalization remains constant; however, the engines that drive the medicalization process have shifted. He describes major changes in medical knowledge and organization and how they heavily influence new genres of medicalization, including biotechnology (especially the pharmaceutical industry and genetics), and managed care.

*Doctors are still gatekeepers for medical treatment, but their role has become more subordinate in the expansion or contraction of medicalization. Medicalization is now more driven by commercial and market interests than by professional claims-makers. The definitional center of medicalization remains constant, but the availability of new pharmaceutical and potential genetic treatments are increasingly drivers for new medical categories (Conrad, 2005, p. 5).*

These changes signal a new urgency for re-examining the medicalization of women's experiences, and its mental health counterpart, psychiatrization. New actors, such as the biotechnology industry, and the pharmaceutical industry, Big Pharma, are now central players in medicalization. These shifts direct attention to the systemic antecedents of the medicalization process, and its perpetuation of

oppressive structures and economic processes that create and sustain women's mental health struggles.

### IMPLICATIONS & CONCLUSIONS

The oppression of women is a central aspect of their mental health concerns. Moving forward to address these relationships must be framed in a social justice perspective, and in particular, one that is informed by critical perspectives on the SDH. Although this approach may seem intuitive, or even obvious, the complexity of oppression means that enacting these changes will be correspondingly complex. There is overwhelming evidence that women's depression, and many other mental health struggles, are grounded in poverty and systemic violence. Yet, there is surprisingly little evidence about the mechanisms and pathways of the biophysical and mental health consequences of women's oppression: How does chronic poverty, and resultant food and heat insecurity, contribute to immune system compromise? Given the systemic nature and extent of violence against women, is traumatic stress a taken-for-granted 'consequence' of being a woman? These kinds of questions underscore the relative infancy of systematic investigation of the mental health consequences of women's oppression, and the urgency of further investigation and action.

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