traditional male domination and less respect for their work place women in an unequal and unfair situation in Iran.

Conclusions

Human rights are founded on the principles that all members of the human family are equal, and should accordingly be granted equal dignity and equal rights. However, where social discrimination against women exists, they are often excluded from effective participation in identifying and securing their rights. In recent years, some have argued that health – defined in the World Health Organization's 1948 constitution as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' – requires the protection and promotion of human rights. With more attention being given to women's rights, some non-governmental organisations, such as Amnesty International, have started to keep accounts of incidents of self-immolation by women. It is necessary to transfer our limited knowledge of this issue (and similar ones) to healthcare professionals around the globe. It is also necessary to inform people in developed countries about female self-immolation, to stimulate attention and discussion of the issues, and generate health research, interventions and policies for the prevention and reduction of self-immolation among women in Iran.

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THEMATIC PAPER – WOMEN'S MENTAL HEALTH AND OPPRESSION

Attitudes to women and their mental health in Mexico

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In Mexico, there are two females with depression for each male (Medina-Mora *et al*, 2003) and the rate among poor females is three times higher than that among those with the highest income (Berenzon *et al*, 1998). Most research findings suggest that depression cannot solely be explained by a simple biological theory but that sociocultural variables also play a major role. These include the different degree of control and power that women and men have over socio-economic determinants and the differences in social position, status and gender role expectations. Traditional gender roles are expressed in prescriptions such as 'women should be passive and submissive in relation to men', while the lower value attributed to them, their higher rates of exposure to violence and other stressful risk factors and their scarce opportunities for development affect women's susceptibility to specific mental health problems. The present paper describes Mexican attitudes towards women and women's exposure to stressful life experiences that may contribute to their increased psychiatric morbidity, and shows what it means to be female in different Mexican contexts.

Despite globalisation and the influence of the feminist movement, traditional roles still prevail in Mexico. The dominant male role is known as 'machismo', which amounts to a cult of virility, where the main attributions are an exaggerated aggressiveness and intransigence among males and an arrogant and aggressively sexual attitude towards women.

Attitudes towards women

Despite globalisation and the influence of the feminist movement, traditional roles still prevail in Mexico. The dominant male role is known as 'machismo', which amounts to a cult of virility, where the main attributions are an exaggerated aggressiveness and intransigence among males and an arrogant and aggressively sexual attitude towards women; the complementary female role is one of submissiveness or the 'syndrome of the suffering woman', which amounts to a cult of superior

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feminine spirituality over males, submission and shyness, their value being in part measured by how much they suffer (Lara, 1993). Men are expected to work outside the house and support the family, and women, especially those of child-bearing age, are expected to stay at home and take care of the children and the elderly.

The assimilation of traditional gender roles varies across social classes, being more prevalent among the poor. The values attributed to females of lower social class have been described as 'being responsible for the family', 'being the male companion' and 'being made for housework', while those attributed to females of higher social class are also 'being the male's companion' but also 'being equal to males' (Lara, 1993).

More depressive symptoms have been reported in women who adopt traits of the traditional passive-submissive role, while feminine affiliation, instrumental-pragmatic traits and androgyny in women are associated with fewer depressive symptoms. High levels of depressive symptoms have been reported among Mexican women at socio-economic disadvantage. They have been found to perceive their roles as mothers and homemakers as not being appreciated or valued by themselves or their families, to experience role conflict and to perceive a lack of choice (Lara & Salgado, 2002). Their role as mothers can be a major source of stress, as they feel they are constantly being evaluated by society, which still views motherhood as the ideal status for women. Further risk of depression arises from difficulties in their relationships with partners, where they feel double standards remain and they have a lower status. At the same time, and perhaps derived from the fact that society expects females to endure adversity, despite being depressed they remain active and are able to fulfil their family and work responsibilities, even when they are not receiving treatment (Lara *et al*, 1996).

Social context of depression

As in many developing societies, gender roles are in transition. Nowadays females have fewer children (an average of 2.2 compared with 7 in the middle of the last century) yet a vocation for marriage is more or less general and it occurs at young ages, because of the high value attributed to the role of housewife.

Social transitions that have forced women to take over roles formerly attributed to men include international migration; furthermore, internal migration, especially the diminution of the proportion of males living in rural communities, has often meant that women have had to perform roles previously attributed to men. Although these social trends have increased the visibility of females and thereby enhanced their role as major contributors to social development, they have not resulted in more benefits for them (Salgado de Snyder & Maldonado, 1992). Similarly, economic crises have forced females, including married women and those of child-bearing age, to engage in paid employment, yet still only 34% of females are economically active, compared with 72% of males; women are still receiving lower salaries and have access to less highly valued employment than males, and therefore earn on average 36–50% less. A feminisation of poverty is being observed, as the proportion of households headed by a woman (presently estimated at 18%) is increasing and these households tend to be poorer than those headed by a man.

Females have higher educational attainment than in previous decades, yet poor females leave school at younger ages than males because education is not regarded as crucial for them. In higher education, to which only 9% of the population has access, these differences disappear, however. For instance, an equal proportion of males and females are university students, yet although 40% of the staff are female, only 25% occupy high positions.

Male roles have not changed at the same rate at which women have adopted more diverse roles. As a result, females are now more stressed and often have a double workload since, in addition to their work responsibilities, they continue to care for the family. In short, many women experience work overload, and there are few resources to help them cope.

Stress derived from having to work and raise small children has been shown to increase the risk of depression, although better mental health as regards depressive symptoms has been found among female employees than among housewives. Hypotheses explaining these findings suggest that employed women increase their sources of social support and have more independence regarding their use of economic resources, whereas being a housewife encourages social isolation and dependence (Lara, 1999). Women in paid jobs still perceive that society is critical of them for not performing full time what is considered their main role as mothers and expects them to compensate for this by being almost perfect.

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Alcohol and domestic violence

Although males are more often victims of violence, females are exposed at an earlier age and to types of violence that profoundly affect their identity and value in a male-oriented society. Rape and sexual abuse are more frequent among females and happen at earlier ages, and this is associated with high rates of post-traumatic stress disorder (Medina-Mora *et al*, 2005).

Few women drink alcohol, but men are expected to drink and occasional inebriation is considered part of the male role. Therefore when females drink and develop alcohol-related problems they are more often socially rejected than are men (Medina-Mora, 2001). It is more common for females to have been abandoned or divorced by the time they receive treatment for alcohol misuse. Rejection is not due to differences in their behaviour from that of males but to the fact that drinking is considered to be incompatible with female roles. Mexican females married to men with alcohol dependence are not likely to increase their drinking; nor do they get divorced more frequently than other women. In

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addition to the feeling of guilt shared with other cultures, Mexican women married to men with an alcohol problem experience shame and are more likely to be financially dependent on their husbands (Natera *et al*, 2002).

Victimisation is also common: 29% of women report having experienced physical violence by their partners, and alcohol is involved in 66% of these cases. The estimated risk of family violence is 3.3 times higher when the male partner is drunk every day than when the partner has no alcohol problems. Depression has been estimated to be 4 times more frequent among women exposed to such violence than among women who have not, and the risk is considerably higher (8 times) when physical abuse has been experienced during pregnancy (Medina-Mora *et al*, 1999). Females have attributed this behaviour to the man's jealousy of the unborn baby and suspicions of infidelity, which challenge masculinity in the local culture.

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Conclusion

Traditional gender roles, increased work overload, fewer opportunities for development and high rates of victimisation have been found to be related to the increased rates of depression among Mexican females, especially among the poor.

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COUNTRY PROFILE

Contributions to the country profile section are welcome: please contact Shekhar Saxena (email saxenas@who.int).

Psychiatry in Spain

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Spain covers an area of some 506 000 km^2 and has a population of just over 41 million. It is a high-income country (according to World Bank criteria) and devotes 7.5% of its gross domestic product to health.

Organisation of healthcare

Spain's National Health System has universal coverage and is financed through the general budget of the state, although the system is organised territorially. Healthcare has two levels: primary care, which is the gate into the system, and specialised care, which is managed independently of primary care, although some regions are considering unifying the two. Psychiatric care is part of specialised care.

Around 6% of the population have additional health insurance and can be treated privately, which gives them greater choice in their healthcare. The private insurance companies set limits on the length of psychiatric hospital

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