

# 13

## Gender and Mental Health: Do Men and Women Have Different Amounts or Types of Problems?

*Sarah Rosenfield and Dena Smith*

Are there differences between men and women in mental health and why? These are the questions taken up by Rosenfield and Smith. They begin by providing an overview of classical psychoanalytical theory (Freud's conceptualization) and more recent approaches (such as by Nancy Chodorow) that represent the major positions on gender differences: Women have more mental health problems than men, men have more than women, or both have equal amounts. Evidence reveals that there are no differences in their overall rates of psychopathology, but men and women do differ in the type of psychopathology experienced. Women suffer from higher rates of depression and anxiety (referred to as internalizing disorders), and men have higher rates of substance abuse and antisocial disorders (referred to as externalizing disorders). Rosenfield and Smith consider various explanations for these differences. They concentrate on dominant gender conceptions – those held by groups in positions of power, which in this society, are primarily White, middle-class conceptions. Divisions between men and women in power, responsibilities (i.e., different role positions), and personal characteristics are relevant for mental health. For example, women earn less money, have jobs with less power and autonomy, and experience an overload of job and family demands more often than men. They have closer social ties, which bring more support but also more negative interactions. Women have personal characteristics of low self-esteem and mastery compared to men, as well as high emotional reliance as opposed to men's greater independence. Finally, men and women differ in self-salience, which constitutes beliefs about the importance of the self versus others in social relations: Women put others' interests first more often, which promotes internalizing problems, while men tend to privilege the self more strongly, facilitating externalizing problems. As African Americans exemplify, the authors suggest that socializing practices encouraging high self-regard along with high regard for others benefit mental health. This is an interesting idea, and students may want to discuss their own socialization into "appropriate" feminine and masculine behaviors.

### **Introduction**

Among the most profound social divisions in our culture is the one we make by gender. Whether we are male or female shapes our access to resources and our life choices and options. It colors the ways we relate to others, what people expect of us, and what we expect of ourselves. Clearly, then, this division should affect our internal states and compasses: the way we feel about ourselves, how we experience the world, and our emotional reactions. Because our social practices are

fundamentally gendered, mental health and emotional troubles should also differ for men and women.

For some time, however, there have been heated debates over the differences between the mental health of men and women. Some argue that women have more psychopathology than men, and some claim men have more. Others think that both genders suffer equally, but from different maladies. In this chapter, we present examples of these conflicting positions, examine the evidence for them, and discuss social explanations for disparities by gender. This discussion ultimately points us to situations that are best for the mental health of men and women.

### **Examples of the Positions on Gender Differences in Mental Health**

Freud was probably the first to design a systematic theory comparing men's and women's mental health. Classical Freudian theory holds that men are superior to women psychically – a view that persists among many today. For these reasons, we start the debate with Freud's approach.

Generally, Freud posited that humans acquire a separate sense of self – including an ego and a superego – in the course of several stages of development. In the phallic stage of development (around ages 3–5), an event occurs that marks the beginning of a radical distinction between the genders in the nature of the self. This event is children's recognition of the genital differences between males and females. At this point, boys are indifferent to or deny the sight of the female genitals (Freud, 1959a). For girls, however, this discovery is a major crisis in their development. In Freud's words, girls "notice the penis of a brother or playmate, strikingly visible and of large proportions, at once recognize it as a superior counterpart to their own small and inconspicuous organ, and from that time forward fall victim to envy for the penis" (Freud, 1959a, p. 190). The "normal" outcome of this crisis for girls is hostility and resentment toward their mother for bringing them into the world "so ill-equipped." As a result, the girl turns from her mother to her father as her primary love object, thereby forming the female Oedipus complex (Freud, 1949, 1959a, 1959b, 1966a).

For boys, the dynamics of development are less complicated. A boy's crisis in the phallic stage comes when his attachment to the mother intensifies and becomes more sexual in tone (Freud, 1949). This desire for the mother and the resulting rivalry with the father constitute the Oedipal situation for boys. In trying to deflect this situation, the parents threaten the boy with castration, which is taken seriously only when he recalls the earlier sight of female genitals (Freud, 1949, 1959a). This results in the castration complex, in which the boy perceives that the girl has been castrated and therefore believes that the threat to himself is real. The boy renounces his desire for possession of the mother and represses the Oedipus complex (Freud, 1949). As the replacement for this loss, the child identifies with the authority of the father and with the position that he will some day inherit. This

identification with the morals and standards of the father forms the basis for the superego or conscience (Freud, 1959a, 1959c).

There are several ways that girls or boys can veer off these normal paths of development. But only for girls is the normal path itself flawed. According to Freud, women are stunted in both ego and superego development. In turning toward the father, girls repress active sexual impulses, which results in passivity as a personality characteristic (Freud, 1959b). Similarly, the shift from mother to father attachment involves turning aggression toward the self, resulting in masochistic tendencies (Freud, 1966b). The wound to girls' self-image in discovering they have no penis predisposes them to more vanity and jealousy than boys (Freud, 1959a). Finally, there is no force comparable to the castration complex in boys to motivate girls to give up the Oedipus complex; they may remain in this situation indefinitely (Freud, 1959a). Because the superego depends on resolving the oedipal situation, girls have a less developed superego than boys do.

Some of Freud's own followers (for example, Horney, 1926/1967; and Thompson, 1942) criticized his positions on women, and critiques have also increased in the past decade. Research on early childhood finds that girls make positive attributions to others of their own gender and to femininity in general, questioning the validity of the idea that girls see themselves as physically and therefore psychologically lacking (De Marneffe, 1997). Rigid adherence to a predetermined, biological unfolding of developmental stages has become more tempered in recent literature, although some retain the assumption that girls and boys differ in thought, behavior, and emotion because of endowment (Friedman & Downey, 2008; Gilmore, 1998).

More recent approaches have turned these general views upside down. For example, Daniel Stern (1985) questions the basic assumptions of Freudian theory as well as most current theories of development (e.g., Erikson, 1950/1963; Kohlberg, 1969). All of these theories assume that humans start out totally connected to the world around them, especially their mothers, unable to make a distinction between themselves and the external world. Mature, successful development involves becoming an independent, self-sufficient, autonomous adult. This version of development links what we think of as masculine (autonomous, separate) with mature, developed selves and links what we think of as feminine (connected, attached to others) with immature, undeveloped selves. Therefore, these assumptions about how people develop favor males and produce the view that male psychology is superior. Stern (1985) proposes instead that humans start out as separate, unconnected creatures and become more and more attached to those around them over time. The self-in-relation theory from the Stone Center at Wellesley posits that females' sense of self is strongly based in their connections to others. The hallmark of maturity is the development of greater and greater complexity in relationships over time (Jordan et al., 1991). Thus, these approaches reverse previous models of development: Connections with others are the mark of maturity, and the model of male as superior is replaced with a model of female as superior.

Some argue that models of female superiority are just as problematic and insidious as models of male superiority. Either way, they piece apart the world and set up destructive hierarchies (Tavris, 1992). A few theories, in contrast, emphasize the problems and strengths in both male and female development. Nancy Chodorow's object relations theory (1978) is probably the best known. Chodorow claims that certain positive and negative characteristics of women and men come from the fact that women are mostly responsible for parenting. Out of their presumed similarity, mothers tend to identify more strongly with their daughters than with their sons. Because of this overidentification, mothers often hold daughters back from experiences of independence. In contrast, sons are pushed away into a position of independence too early. These different ways of treating daughters and sons underlie the development of the self, which is reinforced later by more obvious forms of socialization. Girls are more preoccupied with their relationships with others. This focus gives them a lifetime capacity for rich social connections, more flexible boundaries between themselves and others, and a large capacity for empathy. Boys' greater separateness and distance set them up to adapt effectively to the work world. However, each gender also suffers from tendencies toward problematic extremes. The overembeddedness and lack of separation for girls lead to dependency on others for a sense of self. Low self-esteem also results from identification with a mother whose own self-regard is often low and whose social position is undervalued (Chodorow, 1974). Boys, on the other hand, experience problems with and fears of emotional connection. In sum, Chodorow writes that the results of present family structures for girls and boys, respectively, are "either ego-boundary confusion, low self-esteem, and overwhelming relatedness to others, or compulsive denial of any connection to others or dependence upon them" (Chodorow, 1974, p. 66).

The theories above are examples of the three general views on gender and mental health. Although there are disputes within these approaches, they illustrate the positions that women exceed men in psychopathology, that men exceed women in psychopathology, and that both men and women experience problems but of different types. Given these views, we turn to the evidence on gender differences and mental health.

### **What Is the Evidence on Gender Differences in Mental Health?**

Recent large-scale epidemiological studies have assessed the rates of mental disorders in the United States (Kessler, 1993; Kessler et al., 1993, 1994; Kessler, Demler, et al., 2005). Taking all psychological disorders together, these studies show that there are no differences overall in men and women's rates of psychopathology. It is therefore clear that neither gender is worse off than the other in mental health overall.

However, there are gender differences in particular types of psychiatric disorders. Women exceed men in internalizing problems of anxiety and depression, in which problematic feelings are turned inward against the self. This includes both milder and more severe forms of depression, as well as most types of anxiety, including generalized anxiety disorder and phobias. Greater depression means that more women than men live with feelings of profound sadness and loss, serious problems with negative self-concept, and feelings of guilt, self-reproach, and self-blame. Women experience a great loss of energy, motivation, and interest in life more often than men. They more frequently feel that life is hopeless, coupled with a deep sense of helplessness to improve their circumstances. They more often have trouble concentrating as well as with sleeping and appetite, which can be too much or too little. Greater anxiety means that women suffer more often from fears of specific objects or situations (i.e., phobias), panic attacks, and free-floating anxiety states that attach themselves to seemingly random thoughts and situations (American Psychiatric Association, 2000).

In contrast, men more frequently exhibit externalizing problems of substance abuse and antisocial behavior, which are more destructive and problematic to others. Greater substance abuse means that men more often consume excessive amounts of alcohol and other drugs – in both quantity and frequency – than women. They more often experience extreme physical consequences from substances, such as blackouts or hallucinations. Drugs or alcohol interfere with their lives more often, causing problems at work or school or in the family. Men are more likely to be dependent on a substance, needing to use more and more to get the same effect, and to have serious psychological or physical consequences from attempts to stop. Greater antisocial behavior includes disruptive disorders in childhood and adolescence – such as attention deficit/hyperactivity disorder, conduct disorder, and oppositional defiant disorder – as well as antisocial personality disorder in adulthood. This means that, beginning at an early age, males are more often aggressive or antisocial in a wide range of areas, including violence toward people and animals, the destruction of property, lying, and stealing. Partly as a result, males more often have problems forming close, enduring relationships (American Psychiatric Association, 2000).

In sum, neither men nor women exceed the other in mental health problems, but rather experience very different kinds of problems. Given these findings, we discuss the social explanations for these differences.

### **What Explains the Gender Differences in Mental Health?**

We first give a brief historical perspective on our current dominant definitions of gender. Dominant gender conceptions are those held by groups in positions of power, which, in this society, are primarily White, middle-class conceptions (Connell, 1995). Explanations for gender differences in mental health problems focus on aspects of these dominant gender conceptions and practices.

The rise of industrial capitalism in the 1800s heralded a shift of major consequence in the social situations of men and women. In the agricultural societies before this, both men and women produced goods within the home. In addition to raising children, women had central productive responsibilities such as making clothing and working in the fields along with men. With industrialization, the workplace became divided from the home. Middle-class men began to leave home to work, and women stayed to care for the children in the household. This seemingly simple split in the realms of men and women had ramifications throughout all levels of social and personal life. The productive work of the public sphere became primarily associated with men and masculinity. The socioemotional work and domestic labor of the private sector became primarily linked with women and femininity. A so-called cult of domesticity arose to validate the assignment of women to the private sphere. This middle-class ideology dictated that women were fragile and emotional beings and that children required their mothers' (not fathers') special care for moral and psychic development. Thus it was that public and private realms became divided and gendered: Men belonged in the realm of economic productivity, and women belonged in the realm of emotions, social relations, and caretaking. Consistent with these splits, dominant conceptions of femininity came to associate women with personal characteristics of nurturance, sensitivity, and emotional expressiveness. In contrast, dominant conceptions of masculinity associated men with characteristics of assertiveness, competitiveness, and independence (Connell, 1995; Flax, 1993; Rosenfield, Lennon, & White, 2005).

This division of public and private has had strong implications for power differences between men and women. The economic resources of the public sphere are more transferable than the socioemotional resources of the private sphere (Lennon & Rosenfield, 1994). Money is a resource that can be used or transferred in any context, exchanged for the same rewards, and accumulated without limit. In contrast, caretaking skills and emotional sensitivity are resources that are tailored to particular individuals – one's specific husband, children, or friends – and cannot easily be transferred to other individuals or extended indefinitely. In this sense, the economic resources of the public sphere bring greater power and are hence more socially valued than the socioemotional resources of the private sphere. Because men and women are split along public–private lines, they hold different amounts of power and esteem in the social eye (Rosenfield, 1995).

With this background in mind, we examine the ways these gender conceptions and practices – including the division of labor, power relations, and dimensions of the self – shape the divergent psychological troubles of men and women. The differences in power and responsibilities translate into lower earnings for women than men, even in the same jobs that require the same training and experience – a wage gap caused in part by the devaluation of women's skills (Cohen & Huffman, 2003); Kilbourne et al., 1994). In addition, average incomes are lower in professions where women make up a significant percentage (Cohen & Huffman, 2003).

Often, income is also divided unequally within the family, with husbands receiving more than wives, who spend larger proportions of their share on their children (Becker, 1976). Scores of studies attest to the negative effects of low income on mental health (see Chapter 12 in this volume).

The division of public and private spheres results in women's greater responsibility for domestic labor, regardless of their employment status. Most women are employed currently, including those with small children. Women do the bulk of child care and housework even if they work hours comparable to their husbands outside the home and bring in the same income (Greenstein, 2000; Hochschild & Machung, 1989; Lennon & Rosenfield, 1994; Pleck, 1985). These responsibilities for the household work often result in an overload of demands that raises women's levels of depressive and anxious symptoms (Bird, 1999; Krause & Markides, 1985; Lennon & Rosenfield, 1992; Mirowsky, 1995; Rosenfield, 1989, 1992a). When household tasks are split, women tend to do the kinds of tasks over which there is less discretion and that must be repeated often, such as preparing meals, shopping, cleaning, and laundry. These kinds of tasks produce a strong sense of time pressure, which also engenders depressive symptoms (Roxburgh, 2004). In addition, the stress of managing often unpredictable child care arrangements also takes a psychological toll, and women who have trouble with such arrangements suffer high levels of distress (Mirowsky & Ross, 1988, 1989b; Ross & Mirowsky, 1992). In contrast, when child care is secure and when husbands share the work at home, women's symptoms of depression and anxiety resemble the low levels among men. Thus, women's excess in internalizing problems is partly caused by the greater time pressure of their household tasks and the overload of job and family demands that they experience more often.

The separation of spheres by gender also has consequences for the social relationships of men and women and, in turn, their mental health. Consistent with their identification with the private sphere, women maintain more social ties that are emotionally intimate (Belle, 1987; Turner, 1981). For example, women enjoy higher levels of mattering in relationships; that is, the feeling that others care deeply about them (J. Taylor & Turner, 2004). However, the close ties that bring women support can also be sources of negative interactions, such as conflicts, demands, and guilt (Cohen & Wills, 1985; J. Taylor & Turner, 2004; Turner, 1981, 1994). These negative interactions can offset the benefits of supportive interactions, leaving women with higher levels of distress than men overall (Roxburgh, 2004; Turner, 1994). In addition, women experience more distress over the problems of those they care about than do men (Kessler, McLeod, & Wethington, 1985). For this reason also, women can suffer greater anxiety and depression – what some call the “costs of caring” – from their closer social connections (Kessler et al., 1985; Turner, 1994).

The dimensions of the self that differentiate men and women also have implications for mental health. Gender differences in internalizing and externalizing

problems emerge in childhood and adolescence, which indicates the importance of socialized dimensions of selfhood (Avison & McAlpine, 1992; Compas, Orosan, & Grant, 1993; Gore, Aseltine, & Colten, 1993; Kessler 2000, 2003; Kessler, et al., 1994; Rosenfield, Vertefuille, & McAlpine, 2000; Turner & Lloyd, 1995). Consistent with the divisions in spheres and in power, women have more negative self-evaluations than men, a difference that also arises in adolescence. For example, women have less self-esteem and a lower sense of mastery or personal control than men (Avison & McAlpine, 1992; Barnett & Gotlib, 1988; Craighead & Green, 1989; Nolen-Hoeksema, 1994; Pearlin et al., 1981; Rosenberg, 1989; Rosenfield, 1989). These negative self-evaluations increase the risk of mental health problems, especially internalizing problems. In contrast, high self-esteem and sense of mastery are positive for mental health, operating as personal resources that protect the self in the face of stress (Pearlin et al., 1981; Rosenfield, 1992a; Rotter, 1966; Thoits, 1995). These differences in aspects of the self contribute to women's higher rates of anxious and depressive symptoms (Avison & McAlpine, 1992; Nolen-Hoeksema, 1987; Pearlin et al., 1981).

Consistent with the division into public and private spheres, women possess higher levels of emotional reliance and empathy, whereas men are more independent in relationships (Hirschfeld et al., 1976; Rosenfield et al., 2000; Turner & Turner, 1999). Extreme degrees of connectedness or dependency raise the risk of internalizing symptoms. In contrast, extreme independence and low empathy increase externalizing problems such as antisocial behavior (Guisinger & Blatt, 1994; Hagan, 1991; Hagan & Gillis, & Simpson, 1985; Heimer, 1995; Heimer & De Coster, 1999; Miedzian, 1991; Ohbuchi, Ohno, & Mukai, 1992; Rosenfield et al., 2000; Turner & Turner, 1999). There is some evidence that the gender differences in connectedness and autonomy contribute to the disparities in internalizing and externalizing problems (Rosenfield et al., 2000; Turner & Turner, 1999).

Corresponding to the differences in economic resources, men and women differ in perceptions about the amount of power they possess in relationships. Low perceptions of power raise the risk of internalizing symptoms in particular (Lennon & Rosenfield, 1994; Mirowsky, 1985). For instance, individuals who think they have few alternatives to a relationship endure higher levels of depressive symptoms than those who perceive that they have more options (Lennon & Rosenfield, 1994). Gender differences in perceived power also contribute to the disparities in internalizing symptoms between men and women.

Consistent with these differences, men and women vary in self-salience, which are schemas about the importance of the self versus others in social relations. Basically, self-salience involves who we put first, ourselves or other people. At the extremes, self-salience shapes individuals' tendencies toward internalizing or externalizing problems (Rosenfield, Lennon, & White, 2005). Schemas that elevate others at the expense of the self raise the risk of internalizing symptoms, whereas those that promote the self at the expense of others predispose individuals



to externalizing behavior. Dominant conceptions of femininity privilege the needs of others above the self, whereas conceptions of masculinity privilege the self more strongly. These differences in self-salience help explain why women predominate in internalizing problems and men exceed in externalizing problems (Rosenfield et al., 2005; Rosenfield, Phillips, & White, 2006). Studies showing that internalizing symptoms are associated with lower levels of “masculine” traits are consistent with these findings (Barrett & White, 2002; Bassoff & Glass, 1982; Horwitz & White, 1987; Huselid & Cooper, 1992; Whitley & Gridley, 1993).

All of these gender differences – in power, responsibilities, and dimensions of the self – shape men’s and women’s experiences and reactions under stress, which have implications for mental health. Stressors that challenge valued roles or cherished goals and ideals are especially destructive to well-being (Brown & Harris, 1978; Thoits, 1992). Thus, for example, women’s greater responsibility for caretaking and domestic life can make problems with their children particularly stressful. For the same reason, women feel more distress than men when spending time away from young children (Milkie & Peltola, 1999). There are also different meanings for men and women in combining work and parent roles (Simon, 1995). Men’s conceptions of themselves as paid workers are consistent with their conceptions of being a good parent. They see breadwinning as part of their parental role. For women, paid work and being a parent overlap less – income is not as central to their notion of parenting. Because of these different social conceptions, women with children more often experience intense internal conflicts and challenges to identity when they are employed. These reactions in turn contribute to their higher distress in combining these roles compared with their husbands (Simon, 1995). The costs and benefits of role meanings are different for men and women, particularly for the work role (Simon, 1997). Although most meanings associated with work outside the home are positive for men and women, there is a central cost for women: Work outside the home detracts from time spent with family. Thus, the meaning of work has a cost to women that it does not for men, which helps explain why married mothers have greater internalizing problems than married fathers (Simon, 1997).

Given the differences above, men and women vary in their specific strategies for coping with stressful events and circumstances. Men are more stoic and less expressive in their responses to stressors than women. They more often try to control the problem, accept the problem, not think about the situation, and engage in problem-solving efforts. Women more often pray, solicit social support, express their feelings, and try to distract themselves (Thoits, 1995). Overall, problem-focused coping strategies, which attempt to control the stressful situation and reflect a high sense of mastery, are associated with lower depression and help explain men’s lower rates (Folkman & Lazarus, 1980; Kessler et al., 1985). However, different strategies are effective for particular kinds of problems (Mattlin, Wethington, & Kessler, 1990; Pearlin & Schooler, 1978). Generally, strategies

that keep partners engaged are more effective for interpersonal problems. For impersonal problems like those on the job, coping mechanisms that allow distancing or devaluation of the problem are most helpful. In this sense, women's typical coping techniques stand them in good stead for dealing with problems in relationships; men's techniques benefit them for dealing with problems at work. We see the division of spheres again reflected in this distribution. We also see that flexibility in coping may be the most effective strategy of all, allowing one to use the best technique for the specific problem at hand.

The explanations presented so far hold that gender differences in mental health result from different underlying experiences of women and men, which divisions in power, responsibilities, and aspects of selfhood produce. In contrast, another approach claims that different norms for expressing emotion rather than different underlying experiences explain the mental health disparities. Norms for the expression of emotion, or what are called "feeling rules," vary dramatically for men and women and prompt different responses to similar situations. There are "proper" or "appropriate" ways for men and women to emote, the genesis of which can be explained by differential socialization for boys and girls (Simon, 2002). As suggested earlier, children internalize messages that equate masculinity with assertiveness, dominance, aggressiveness, independence, and risk-taking, but girls are raised to be the opposite, most notably nurturing and caring (Hagan, 1991; Hagan et al., 1985; Heimer, 1995; Heimer & De Coster, 1999; Miedzian, 1991; Steffensmeier & Allan, 1991). Males are expected to suppress emotions defined as feminine and weak, such as feelings like helplessness, worry, and insecurity – all of which are associated with anxiety and depression. Anger is somewhat more tolerated even though not welcomed. In contrast, emotions such as fear and helplessness – consistent with anxiety and depression – are more normative for women (Simon, 2007; Simon & Nath, 2004).<sup>1</sup>

Some argue that these feeling rules leave men and women little choice in expressing their troubles. For example, because open displays of anxiety and depression are relatively forbidden, men may attempt to hide, remove, shorten, or deflect any such feelings. Drinking accomplishes this goal, under the cover of relative acceptability. For these reasons, some see substance abuse as a male version of depression; that is, a gender-equivalent expression of depression (Horwitz et al., 1996b; Rosenfield et al., 2005). Both come from the same underlying feelings, one allowing direct expression and the other indirect. As some evidence of this,

<sup>1</sup> Cross-gender emotions such as anger and antisocial behavior are discouraged. We can witness the operation of these norms clearly when men and women display the "wrong" emotional problems for their gender. For example, men who come into psychiatric emergency rooms with depressive symptoms are hospitalized at much higher rates than women with the same symptomatology. Likewise, women who come in with antisocial disorders or substance abuse are more likely to be hospitalized than men with the same problems. These cases of double deviance are treated much more severely, showing us there are norms even in deviating (Rosenfield, 1984).

low-level jobs increase psychological distress for women and increase drinking for men. Thus the same problematic circumstances can result in divergent disorders in men and women (Lennon, 1987).

### **What Are the Best Situations for Men's and Women's Mental Health?**

Based on the evidence presented, we can point out some conditions that are positive for women and for men. The same principles hold for both genders: Greater power and reasonable levels of demands are beneficial for mental health. Thus, for women or men, one positive situation is full-time employment when there are no children in the home. Women who are employed part time with kids at home also seem to be in good shape (Rosenfield, 1989). Those women who work full time with kids at home benefit only if they have secure child care arrangements or if their husbands share in the domestic labor, especially in the highly time-pressured tasks. Because men and women gain and lose from the same conditions, a danger is trading off benefits for one gender at the expense of the other. For instance, there is evidence that, when married women's income increases, so does their happiness, both in terms of mood as well as feelings about their marriage (Rogers & DeBoer, 2001). However, wives' greater income can result in lower well-being among husbands (Rogers & DeBoer, 2001; Rosenfield, 1992b).

Within the workplace, high job autonomy and complexity – as well as low time pressure – are the most positive conditions for mental health for both men and women. Other research shows that positive job conditions can even offset negative family arrangements. Specifically, high autonomy and low time pressure on the job reduce the stress women experience in combining jobs and families and the negative effect of child care demands (Lennon & Rosenfield, 1992).

It is also clear that certain kinds of social relations and dimensions of the self are quite beneficial for men and women. High self-esteem and mastery are necessary for optimal mental health. Balanced self-salience – that is, equal esteem for the self and others, equal amounts of autonomy and connectedness, and equal regard for one's own and others' interests – reduces the chances of veering toward externalizing or internalizing disorders.

In concluding, we have reviewed some of the evidence for differences between men and women in mental health and the social underpinnings of those differences. Looking at numerous levels, from macro-level broad sociohistorical forces to micro-level aspects of the self, we see how social differentiation by gender shapes the psychological problems of men and women. One side of the division involves a constellation of low power and caretaking responsibilities; low levels of self-evaluations, autonomy, and self-salience; and feeling rules dictating expressivity of less potent and active emotions – all of which are consistent with internalizing disorders. The other side consists of a constellation of greater power and productive

responsibilities; high levels of self-evaluation, independence, and self-salience; and feeling rules of emotional stoicism with the exception of more potent and active emotions – which are consonant with externalizing disorders

This is not to underestimate the variation that exists between groups in this society. Most research on gender and mental health compares all groups of men to all groups of women, rather than comparing within different subgroups. Gender differences do vary by race and ethnicity; for example, African Americans differ in gender conceptions and gender differences in mental health problems (Rosenfield, et al., 2006). Although these interactions are beyond the scope of this chapter, we recommend their further investigation.

In addition, there is substantial variation that exists among men and among women. As many observe, there is great diversity among particular men and women. We also do not want to go to the other extreme and imply that there is something necessary about these differences. Ultimately, gender differences are largely caused by things other than gender. They are a result of certain social practices such as economic inequality, that have become associated with gender but whose associations can be altered. Going full circle back to Freud, we can trace the advances in understanding the differences between the genders, showing us that anatomy is not necessarily destiny. Instead, a complexity of social forces converges to push men and women toward different psychological troubles. The more we understand these forces and their sources and consequences, the more reasons and power we gather to change them.