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Why talk about gender and mental health?

Luciana Ramos-Lira[1]

Editorial

Interest in issuing a number devoted to gender and mental health arises from certain concerns related to the consistent differences between women and men in some mental disorders in different countries and cultures. Do such differences result from sex or gender? Is gender a risk factor for mental health that operates in the same way in men and women?

Obviously, these questions, rather than referring to mental health as such, refer to mental health problems to the extent that there are few indicators that may account for the latter. Therefore, it is worth considering some data.

In the book *The stressed sex: Uncovering the truth about men, women, and mental health*,[1] the authors examine 12 national surveys on mental disorders comparable to one another, and include surveys conducted in Great Britain, Germany, United States, Australia, New Zealand, Chile and South Africa. The authors conclude that women have higher prevalence and are more likely than men to get depression and anxiety. Men have higher prevalence of abuse and dependence on alcohol and other substances. Although not all surveys cover other disorders, Freeman and Freeman[1] report that, according to some surveys, women are more likely to develop a borderline personality disorder and eating disorders, whereas the prevalence of conduct and antisocial personality disorder is higher in men. In general, the fact that women not only have higher rates of mental disorders than men, but more severe and disabling symptoms stands out.

As for what happens in our country, depression —either as symptomatology or as mental disorder— is also more prevalent in adult[2,3] and adolescent women.[4] Major depression ranks fourth among the top five causes of years of life lost in health issues in Mexican women.[5]

What factors are associated with these mental health problems? A review of Berenzon et al.[6] points out that one of the main psychosocial factors associated with depression in the Mexican population is precisely being a woman, especially when being a family head or when a woman is exclusively dedicated to housework or to take care of an ill person. Other psychosocial risk factors are related to low socioeconomic status (due to increased exposure to precarious conditions because, although there are no significant differences between socioeconomic strata, people from the lowest levels have more severe depression), unemployment (especially men), social isolation, legal problems, experiences of violence, substance abuse and migration.

Thus, in general, it seems that women's mental health is more vulnerable to be affected by certain social factors; however, it is also likely that men underreport mental health problems because of their difficulty to seek help if any emotional distress afflicts them. Likewise, it has been noted that depression in men can be "hidden" behind addictive and risk behaviors as well as behind irritability and impulsivity.[7] As for depression being a woman is considered a risk factor, being a man fulfills the same role for violence.[8]

Then, when we refer to this type of circumstances and factors associated with the condition of being a man or a woman, what do we mean?: sex or gender? We should take into account that sex refers to the biological differences between men and women, and that gender, in turn, refers to the social meaning built around these differences in particular historical contexts. Therefore, gender as a category refers to a symbolic construction through which certain characteristics are attributed to belong to one or the other sex, which set this as a primary axis of the formation of subjective identity and social life involving relationships of inequality owed to unequal (avoidable and unfair) distribution of power and resources.[9] Historically, "masculine" has been considered superior to "feminine", and women have been placed in a position of (receptive and passive) vulnerability versus (active and aggressive) men. This has led to a construction of what we may call a "feminine" or "masculine" subjectivity, so that behaviors of woman or man are perceived as "natural" attributes emanating from their body physiology.[10] That is, gender is invisibilized and sex overlaps as an explanation for virtually all human phenomena; for example, we normally say "so are men" or "it's women business", so their permanence and resistance to change seem inevitable.

In the more specific field of health, it is not clear what differences in health are the result of sex differences and

[1] Guest Editor.
Department of Epidemiological and Psychosocial Research, Ramón de la Fuente Muñiz National Institute of Psychiatry.

which are due to gender, except some differences related to reproductive health.[11] In fact, it is becoming increasingly evident that "our bodies are too complex to provide final answers about sex differences".[12]

In general, when speaking of gender, reference has been made to women-considering the historical situation of inequality that women have suffered because of this, which left out men from research for too long. It is therefore not surprising that —in spite of the fact that there is increasingly a greater recognition that gender is a significant sociocultural factor in the healthy or health-related behavior— male health is seldom deconstructed through the gender vision.[13]

All of the above confirms the importance of research with a gender perspective, leaving again clear that gender, as a social construct, and gender, as a biological construct, are different non-interchangeable terms. Scientific literature, particularly in fields of psychiatry and other medical disciplines, as well as psychology, often confuse these terms and use them interchangeably. As Krieger points out: "The relevance of gender relations and of sex-linked biology in a given health outcome is an empirical question, not a philosophical principle; depending on the outcome under study, none, both, or either may be relevant, either independently or as synergistic determinants. It is therefore essential to clarify concepts and to address sex and gender in order to have valid health research ".[14]

Social determinants often exacerbate biological vulnerabilities, thus a health approach related to gender should consider the way inequality affects health experiences. The above may be used to identify appropriate responses of the health care system and public policy.[15]

Due to the topics tackled and methodologies used, the articles presented in this issue are a contribution, in many ways, to this complex articulation between gender and mental health. The articles written by researchers from the National Institute of Psychiatry "Ramón de la Fuente Muñiz" make up just a small sample of the number of lines of research developed for years in this institution, which results have been published in this journal. Some examples are the interpretive qualitative studies conducted by Martha Romero about women, addiction and prison, which have become a national and international benchmark;[16,17] others are those of Guillermina Natera and Marcela Tiburcio about domestic violence,[18,19] those of María Teresa Saltijeral on the same line,[20] as well as those of Gabriela Saldívar about rape myths[21] and sexual coercion.[22]

Another issue that has been demonstrated is the burden that women have for being the main informal caregivers of psychiatric patients, as shown by María Luisa Rascón's research.[23] Emotional distress and depression in men have been investigated from a gender perspective,[24] among other lines.

This issue includes very valuable articles with a great thematic and methodological diversity. The first two articles tackle the impact that phenomena associated with women reproduction can have on mental health.

On the other hand, Russo makes a superb literature review on a controversial subject that has to be tackled in terms of research: abortion. The title is "Abortion, Unwanted Childbearing, and Mental Health". Russo poses that one of the consequences of not having access to effective contraception is unwanted pregnancy, which physical and mental implications include unsafe abortions or unwanted childbearing. This article systematizes the literature on the abortion and unwanted childbearing relationship with mental health problems, reporting the methodological problems of much of the research in this field.

Although the majority of abortions are performed in African and Latin American and Caribbean countries, in conditions of insecurity and lawlessness, research in mental health risks has been made in women who had abortions legal in developed countries, where only one out of seven abortions worldwide takes place. But there are also other methodological problems, developed in a long section by the author, where three aspects stand out as the most important: systematic biases in the sample selection and comparison groups; conceptual and definitional issues; and aspects related to the desire for getting or not getting pregnant.

The consequences on the mental health of women who abort are also controversial, to the extent that "damages for abortion" have been used to justify restrictions on performing abortions without considering women's reasons. Thus, it is assumed that having an abortion is a major threat to the mental health of pregnant women compared to having and raising an unwanted child.

We should bear in mind that unwanted pregnancies often occur more frequently in certain subgroups of: low-income and very young women and/or with stories of child adversity and gender-based violence, who also tend to have fewer resources to cope with stressful situations.

On the other hand, although the article makes clear that the experience of abortion is not *per se* a significant risk factor for developing a mental disorder, Russo does not have doubts in pointing out the studies showing that some women may have negative emotional responses after an unwanted pregnancy ending in abortion. These responses are related to the way in which experience is evaluated, at a large extent due to the stigma around abortion.

Another aspect that is necessary to highlight is the impact of pregnancy and unwanted childbearing on physical and mental health of women and their families. For example, unplanned childbearing is associated with delays in early childhood development and with deficits in cognitive, emotional and social processes that may occur at various stages of life and passed from one generation to another.

Undoubtedly, this is a fundamental article that leaves open reflection on the fact that low-income women are always the most affected by the practice of unsafe abortions. As for high-income women, whether abortion is legal or illegal, subsidized or expensive, they can pay qualified phy-

sicians that may perform abortions. Then, impacts on the mental health of an unwanted pregnancy will also be higher, in contexts of adversity, so a necessary line of research is open in Mexico and Latin America.

In turn, the article by Lara et al., entitled "Acceptability and Barriers to Treatment for Perinatal Depression. An Exploratory Study in Mexican Women", presents the results of a research conducted in a health center and a general hospital in order to learn if these women recognize perinatal depression and if they accept various forms of care for this condition, and what is their perception of the barriers to attend treatment.

Although there is evidence that a significant percentage of mothers suffer from perinatal depression, the number that is actually detected and treated is unknown. The results of this paper show that, while almost all participants had heard the term postpartum depression, a quarter of them did not know the causes of the disorder, which they attributed to not knowing how to face new challenges, emotional and hormonal changes and to the lack of social support. Most of them felt that it is not easy to talk about sadness or distress within this period and that people would not understand it, largely because of the "bad mother" image that people would have of them if they commented on this. Individual psychotherapy was the most widely accepted treatment and medications, during pregnancy and breastfeeding, the less accepted. The main barriers to treatment were: lack of time, institutional procedures, the inability to afford it and the difficulty for getting someone for taking care of children.

The results are a first step towards defining the needs that women have with respect to perinatal services for treating depression during this period. Lara et al. state that in order to provide effective care it is necessary that official rules governing health care of women and infants during this period include care for mental disorders.

Undoubtedly, these two articles constitute a major input on the implications of pregnancy, wanted or unwanted childbearing and abortion. Also, they report that it is essential to create decision contexts in sexual and reproductive terms based on information terms, access to contraception and mental health care.

Here are three other articles addressing issues related to emotional distress and its care. The article "Structural stigma, mental illness, gender and intersectionality. Implications for mental health care", written by Mora-Ríos et al., addresses structural or institutional stigma as a set of rules, policies and procedures of public or private entities that restrict the rights and opportunities of people with mental illness, legitimize power differences and reproduce inequalities and social exclusion. The authors point out their usefulness for addressing social groups with multiple conditions of vulnerability. These conditions involve various social determinants, interrelated and expressed in social inequalities in health, including gender as a crosscutting structural variable. From this point, the authors resume the intersectionality approach that seeks to explain the complexity of social phenomena in order to understand how sex and gender are interrelated with other dimensions of social inequality —and in specific historical and geographical contexts— to create unique experiences in the area of health. This framework is used to describe the most common forms and manifestations of structural stigma about mental disorders from the perspective of healthcare workers and service users in outpatient treatment in four psychiatric care centers located in Mexico City.

In this regard, the results of service users' perceptions regarding the reason for their suffering are particularly notable social vulnerability: poor living conditions, violence and substance abuse, as well as the lack of a support network. Their findings also show that gender influences these experiences of mental illness and distress; women are most often victims of gender violence and men consume more alcohol. The main sources of stigma, from their point of view, are family and healthcare staff. The latter give service users little credibility and discredit them if they report any experience —including violence or sexual abuse— as if they were not trustworthy and as if their suffering led them to lie or distort information. Furthermore, the stigma towards mental illness affects service users, but also healthcare staff, as detailed in the article.

Poverty and lack of resources for being able to receive proper healthcare constitute structural variables that, like gender, affect the presence of psychiatric disorders. It is therefore understandable, albeit not justifiable, that healthcare staff experience helplessness and uncertainty about the many problems posed to them by service users, which may lead to neglect or indifference, as well as signs of burnout.

However, there are many institutional barriers that such staff take into account for carrying out their work, from physical aspects to human resources and training. The government is also challenged regarding its role in the subject of mental health and conditions of social inequality in the population.

Undoubtedly, this work represents a major contribution to the large number of factors that interact with gender and that are reproduced structurally into the care practices and procedures. The foregoing perpetuates stigma towards people with mental disorders, but also towards service providers serving a heavily discriminated population with multiple vulnerabilities associated with its condition.

The next two articles explore emotional distress: one article focused on women attending primary care and the other one focused on men engaged in family violence. Both articles are of great interest to the extent that talking about mental health is not confined only to patients suffering from a specific disease, but also refers to the population as a whole. "It is a fact that primary care services are receiving more and more patients presenting a more or less diffuse symptomatology of emotional distress. In most cases, there are minor alterations or adjustment disorders related to the psycho-biography of each person and to our social, economic, family and geographic reality. This *discomfort* does not necessarily

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entail a disease; however, it involves a significant degree of unease, regarding people who suffer from it, which makes its care and treatment very convenient" (Preface).[25]

The article by Berenzon Gorn, Galván Reyes, Saavedra Solano, Bernal Pérez et al. "Exploring the emotional distress of women who attend primary health care units in Mexico City. A qualitative study", suggests that there is a tendency for women to go to health centers because of certain feelings and complaints that are often not detected or are minimized by healthcare staff. This kind of neglect is also approached from a structural and institutional perspective, posing that it leads to what is called "over-use of services". This neglect causes suffering in patients, frustration among healthcare staff and a major economic impact on the healthcare system.

The findings of this paper show that the main triggers of emotional distress in participants are associated with everyday concerns (such as lack of money, problems with children and domestic violence) and, in other cases, with traumatic experiences of violence and sexual abuse, both past and present, which is consistent with studies on the subject. This distress is expressed as restlessness, nervousness, irritability, hopelessness and sudden changes of mood, as well as some physical ailments. Participants do not consider that medical appointments are the ideal place to talk about what is bothering them in their daily lives, because consultation times are very short and often doctors lack the skills and knowledge required to give adequate care. Additionally, these women tend not to discuss their concerns and sufferings due to shame or fear of being scolded or judged. It should be noted, as the article makes clear, that they are not asked about this either. Thus, according to the service users there is an obvious need for a more sensitive and empathic listening by staff, especially medical staff.

On the same line, Bolaños Ceballos created the article "Socially-determined psychological distress and expressive abuse in men", where he addresses the case of men who attend a re-education program after exercising family violence. With the purpose of conceptualizing such violence, the author refers to instrumental and expressive aspects, to the extent that he considers instrumentality as a strategy of intimidation at the service of the domination consciously "chosen" by the men from their social position. As for its other "expressive" sense, violence can be understood as a regressive experience, related to life history and experienced as a feeling of being "lost", which occurs in parallel with the instrumental sense. Expressive violence is characterized by violent behavior, carried out impulsively and motivated by feelings of anger and rage, which is usually aimed at those who have less power; that is, at those who are judged as inferior due to gender or age. Also, from the ecological model, the author considers violence in family relationships as a symptomatic manifestation that synthesizes two tensions related to distress: cultural-social and personal-psychological tension.

Bolaños Ceballos argues that it is necessary to talk about "expressive abuse", to the extent that it refers to acts of expressive violence arising in a bond of trust, the reason for which the violence is specifically abusive, since it would not occur in other relationships. These acts are symptomatic of a number of social variables filtered, negotiated and reworked by the personal experience of subjects and expressed in their health and social practices.

In his qualitative approach, the results reveal that the emotional distress of such violent men is expressed in muscle pain, insomnia, nightmares and changes in usual behavior as manifestations of stress. All men mentioned in the article have a history of violence, either because they witnessed violence between their parents, or because they suffered direct violence, which was mostly emotional. Work, or its absence, or a low salary are among the factors mentioned as associated with their distress. Moreover, these men consider that the health system does not cover their needs, which makes them feel anger, helplessness and stress, since they think that this situation will not change. They also have a negative opinion about the government programs and officials. They feel cheated in this regard and consider that these macro-social aspects directly affect their income.

As for expressive abuse, Bolaños Ceballos points out that all social stressors and environmental frustrations mentioned in his article become a latent discomfort, like a pressure cooker, before which "a trigger is sought" to exercise violence. The author emphasizes that, in these cases, there is an expression of violence aimed at someone "inferior" in the power relationship and usually this person is a family member. The beliefs that give rise to expressive abuse have to do with the superiority of men, the physical inferiority of women and children, the ownership of the wife and the obligation for a "lifelong" relationship, as well as beliefs about the use of violence in relationships.

This paper certainly provides some clues about the development of social determinants of psychological distress coming from the macro-social level. It also poses that gender re-education is critical for addressing social injustice and unsatisfied basic needs. The article leads to further reflection on the importance of exploring whether these distresses and violent behaviors mask a depressive background, as stated in the literature mentioned.7

The following two articles are valuable to the extent that they present qualitative methodologies closely related to the social anthropology field.

Roy Gigengack's article, "*La banda* and their *choros*. A group of street children narrating tales about leadership, gender and age", is the result of fieldwork conducted over two decades ago. However, it remains valid regarding the problem it addresses and because it represents an excellent example of what the ethnographic work is. The description used in this article may be considered as "dense", to the extent that it reports the meaning of leadership and the role

that gender and age play in order to organize a street gang after the observation that Gigengack made for by three years with a group of street children in Mexico City.

He argues that homelessness creates a world of paradoxes and contradictions, which also allows a differentiation of power among people relatively lacking of it. Gigengack argues that the stories told by the children and youth of this gang —as for leadership, gender and age— hide their weakness, because in these stories street children assume a power which actually they lack of. He says that this is not a sign of madness or of a manipulative personality, which would be a psychologizing interpretation. This phenomenon rather refers to the creativity and resilience of these children.

The contradiction between strength and vulnerability evident in them is exemplified by the changes that show leadership structure and the original exclusion of women from their ranks, leading to build a new history of the gang. Many of the leadership stories included in the article were focused on the ability of a leader to protect them and contain their self-destructive inclinations. In the case of women, it also highlights the vulnerability that they may experience due to their gender, but that also can be reconfigured giving them power over men when women exercise a "pseudo-mother" role and when establishing an erotic bond.

All this allows us to notice that the spatial-time co-ordinates of the gender, age and leadership make possible other ways of organization, ways to wield power when, socially, one lacks of it, as well as creating stories allowing to narrate the daily vicissitudes of forms that, in fact, are not just fanciful, but creative ways to survive in a world they perceive as unfair.

On the other hand, the Gutiérrez and Vega's article "Symbolic Violence of Women's Sexual Exploitation at a Student Party" is an excellent example of how violence against women is not reproduced only in the most obvious ways. From the analysis of a theatrical representation of trafficking for sexual exploitation that is made in a traditional student celebration, the authors describe it as a ritual that disrupts the school routine and everyday life, though, as they point out, displaces dissimilar elements and senses from their everyday context. While the celebration starts in a tribal way where the emotion, pleasure and playfulness of "hanging together" are shared, Gutiérrez and Vega show how, as the celebration develops, they become a complacent assertion of male chauvinist beliefs and practices that legitimize sexual exploitation, as well as a tacit acceptance of abuse, which is not recognized as such but instead as a venerable tradition. Abuses of power and the role of sexual commodification attributed to women, which are evident in the dramatization of sexual exploitation suffered by female slaves, are in fact considered as a "harmless game", and the women themselves involved as "slaves" cast doubt on the reality of facts. In other words, the meaning of the violent acts they underwent does not occur to them, although the experience has been distressing.

Thus, Gutiérrez and Vega stress that the symbolic violence that portrays the trafficking representation hides the reality of direct and structural violence in the context of this celebration as a chauvinist practice. As pointed out by Bordieu,[26] women have incorporated into their identity the structures through which their domination is embodied; therefore, submission is not the effect of an act of conscience and will. In this regard, Bordieu himself points out: "This is the case of sexual domination, a form of symbolic domination exercised with the complicity of those who suffer it or, more precisely, with the complicity of the built structures that the dominated have acquired through prolonged confrontation with the objective structures of domination".[26]

Finally, two articles address a highly vulnerable population virtually not studied in our country: sex workers. Both articles show results from the same research conducted in the state of Hidalgo, and despite methodological limitations, arising from the difficulty in accessing these women, they entail efforts to visualize the mental health problems that may affect them, beyond considering them exclusively as carriers of sexually transmitted diseases (STDs).

The first of these two articles, called "Psychosocial correlates of depression and suicide risk in Mexican sex workers", by González-Forteza, Rodríguez, Fuentes, Vega and Jiménez, reflects the severity of these problems. According to the article, two in five of these women suffer from depression, a percentage much higher than the prevalence of any affective disorder in women of the general population, which may be about 3%. A similar proportion reported risk of suicide –including suicide ideation and intent – also in a higher level than the women in the general population in our country. Moreover, one in four women has both problems simultaneously.

According to this article, violence is a major factor affecting depression and suicide risk in these women. This factor is reported as emotional rejection and negligence by the mother, child sexual abuse, and emotional abuse from a partner. In turn, alcohol and sexual violence are factors that specifically predict suicide risk.

These different forms of violence and their effects on the presence of depression are not the only ones experienced by these women, as mentioned in article "Violence in the working environment of sex work and substance use in a group of Mexican women", by Rodríguez, Fuentes, Ramos-Lira, Gutiérrez and Eunice Ruiz. As shown in the literature review, sex workers around the world, particularly those working on the street, have mortality rates six times higher than the general population and face a range of social issues that overlap: poverty, incarceration, substance abuse, risk of infection with HIV, and partner violence. These women are also at greater risk of assault, rape, and other forms of physical violence. High alcohol consumption is also reported, as well as the use of drugs such as cocaine, *crack*, marijuana and heroin.

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In this regard, a lot of adversity and forms of violence faced by sex workers suggest that substance use may well be a mitigating mechanism to help them deal with daily sex work.

The results of this paper show that these women do indeed work in conditions of violence that make them highly vulnerable. According to this data, half of them have been exposed to violence, particularly physical, but also sexual. The women interviewed mentioned that these forms of violence have been exercised against them by clients, bar owners and police officers. However, they also report their sex workers colleagues as the main sources of violence, specifically due to competing for clients.

Almost all sex workers interviewed reported having consumed alcohol in the past month, a consumption that seems to be promoted by its high availability and the strong pressure from both clients and bar owners to drink while working. As for the use of other drugs while performing this work, the most commonly used are cocaine and marijuana. In addition, tobacco is an important problem, which may also serve as a mechanism to cope with anxiety.

All these findings reflect the seriousness of the situation these women have to deal with, a fact that should be considered to improve health services to which they should have access. These services should include attention to mental health problems such as depression and abuse of alcohol, drugs and tobacco and should incorporate specialized interventions on partner and workplace violence and childhood abuse. It should also be necessary to consider ways to protect sex workers in these contexts of high violence, which would imply major changes in terms of public policies considering these women as citizens deserving all rights.

As seen from the above, there is much to do in the fields of research and intervention, and this is just an example of what is possible and necessary to deal with, including the conceptual discussion of sex and gender, their links with mental health and the various factors that influence this discussion. All the aforementioned stresses that gender violence is a very serious issue associated with the different problems and that, therefore, it is necessary to keep considering this topic and to design specific studies which have an effect, in turn, in its reduction. Unfortunately, much of the background of this violence is embedded in sociocultural aspects, in stereotypical beliefs about what women and men are and should be, so that symbolic violence operates invisibly and is reproduced by the entire society, and not only by those who exercise it and by those who suffer from it directly. Gender inequality, which involves discrimination and violence, also permeates the institutions devoted to mental health. As can be seen, we have a big challenge ahead. Our challenge should also include dealing with men in their gender condition and promoting recommendations for public policies.

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REFERENCES

1. Freeman D, Freeman J. The stressed sex: Uncovering the truth about men, women, and mental health. Oxford: Oxford University Press; 2013.
2. Bautista CF, Velázquez JV, Icaza MEMM, López MM, López MDLG, Robles NO. (2012). Sociodemographic and personal factors related to depressive symptomatology in the Mexican population aged 12 to 65. Revista Brasileira de Psiquiatria 2012; 34(4):395-404.
3. Rafful C, Medina-Mora ME, Borges G, Benjet C, Orozco R. Depression, gender, and the treatment gap in Mexico.Journal of affective disorders 2012; 138(1):165-169.
4. Benjet C, Borges G, Medina-Mora ME, Méndez E, Fleiz C, Rojas E, Cruz C. Diferencias de sexo en la prevalencia y severidad de trastornos psiquiátricos en adolescentes de la Ciudad de México. Salud Mental 2009; 32(2):155-163.
5. Lozano R, Gómez-Dantés H, Garrido-Latorre F, Jiménez-Corona A, Campuzano-Rincón JC, Franco-Marina F, Medina-Mora ME, Borges G, Nagavi M, Wang H, Vos T, López AD, Murray CJL. La carga de enfermedad, lesiones, factores de riesgo y desafíos para el sistema de salud en México. Salud Publica Mex 2013; 55:580-594.
6. Berenzon S, Lara MA, Robles R, Medina-Mora ME. Depresión: estado del conocimiento y la necesidad de políticas públicas y planes de acción en México. Salud Pública de México 2013; 55(1):74-80.
7. Dumais A, Lesage AD, Alda M, Rouleau G, Dumont M, Chawky, N, Turecki G. Risk factors for suicide completion in major depression: a case-control study of impulsive and aggressive behaviors in men. American Journal of Psychiatry 2005; 162(11):2116-2124.
8. Ramos Lira, L. Género y violencia. En: de la Fuente JR, Heinze G. (eds.) Salud Mental y medicina psicológica. México: McGrawHill/UNAM; 2012.
9. Gómez EG. Equidad, género y salud: retos para la acción1. Rev Panam Salud Pública 2002; 11(5/6):455-461.
10. Ramos L, Saucedo I. La agresión y la violencia de género en seres humanos. En: Muñóz-Delgado J, Díaz JL y Moreno BC (coords.) Agresión y Violencia. Cerebro, comportamiento y bioética. INPRF/HERDER: México; 2010.
11. Lohan M. How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health. Social science & medicine 2007; 65(3):493-504.
12. Fausto-Sterling, A. Cuerpos sexuados: La política de género y la construcción de la sexualidad. Barcelona: Editorial Melusina; 2006.
13. Evans J, Frank B, Oliffe JL, Gregory D. Health, illness, men and masculinities (HIMM): a theoretical framework for understanding men and their health. Journal of Men's Health 2011; 8(1):7-15.
14. Krieger, N. Genders, sexes, and health: What are the connections—and why does it matter?. International Journal of Epidemiology 2003; 32(4):652-657.
15. Sen G, George A, Östlin P. Incorporar la perspectiva de género en la equidad en salud: un análisis de la investigación y las políticas. No. 14. Pan American Health Org, 2005.
16. Bermúdez EC, Mendoza MPR, Ruiz EMR, Durand-Smith AL, Hernández GJS. Female depression and substance dependence in the Mexico City penitentiary system. Salud Mental 2007; 30(6):53-61.
17. Romero Mendoza M., Saldívar G, Loyola L, Rodríguez E, Galván J. Inequidades de género, abuso de sustancias y barreras al tratamiento en mujeres en prisión. Salud mental 2010; 33(6):499-506.
18. Rey GN, García FJ, Sainz, MT. Validez factorial de una escala de violencia hacia la pareja en una muestra nacional mexicana. Salud mental 2004; 27(2):31-38.
19. Tiburcio Sainz M, Natera Rey G, Berenzon Gorn, S. Utilización de servicios de atención a la salud mental en mujeres víctimas de violencia conyugal. Salud mental 2010; 33(3):243-248.
20. Saltijeral MT, Ramos LL, Caballero MA. Las mujeres que han sido víctimas de maltrato conyugal: tipos de violencia experimentada y algunos efectos en la salud mental. Salud Mental 1998; 21(2):10-18.

21. **Hernández GS, Lira LR, Méndez MTS. Validación de las escalas de aceptación de la violencia y de los mitos de violación en estudiantes universitarios. Salud mental 2004; 27(6):41-49.**
22. **Hernández GS, Lira LR, Mendoza, MR. ¿Qué es la coerción sexual? significado, tácticas e interpretación en jóvenes universitarios de la ciudad de México. Salud Mental 2008; 31(1):45-51.**
23. **Rascón GML, Gutiérrez LML., Valencia CM, Murow TE. Relación entre la emoción expresada por el familiar responsable y la conducta sintomática de pacientes con esquizofrenia, incluido el funcionamiento social. Salud mental 2008; 31(3):205-212.**
24. **Fleiz Bautista C, Ito Sugiyama M, Medina-Mora Icaza M, Ramos Lira L. Los malestares masculinos: Narraciones de un grupo de varones adultos de la Ciudad de México. Salud mental 2008; 31(5):381-390.**
25. **Fraile JS, Sampere VE. Malestar emocional: Manual práctico para una respuesta en atención primaria. Generalitat Valenciana: Conselleria de Sanitat; 2012.**
26. **Bourdieu, P. Symbolic violence. Revista Latina de Sociología 2012; 2:1-4.**

Translation of the original version published in spanish in:
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