



Depression in Women on a Global Level: Cultural Perspectives, Social Determinants, Gender Inequalities, and Implications for Mental Health Care

Bernice Roberts Kennedy

BRK Global Healthcare Consulting Firm, LLC

Abstract: Background: Depression is a leading cause of disability worldwide and represents a significant public health concern. Women experience disproportionately higher rates of depression than men across diverse cultural, social, and economic contexts. Multiple factors contribute to this disparity, including social inequities, gender-based violence, caregiving responsibilities, reproductive health transitions, and limited access to healthcare services. Despite growing recognition of depression as a global health priority, substantial disparities in diagnosis, treatment, and mental health resources remain across populations and healthcare systems. Method: This article presents an integrative review of the literature examining the global burden of depression among women, with a focus on cultural perspectives, social determinants of health, gender inequalities, risk factors, assessment practices, and treatment challenges. Evidence was synthesized from peer-reviewed research, global mental health reports, and public health literature examining depression across diverse populations and healthcare settings. Sources included narrative reviews, integrative reviews, systematic reviews, and scoping reviews published during the past decade. The review is guided by a conceptual framework that illustrates the complex interaction of epidemiological, cultural, social, and healthcare factors influencing the experience, assessment, and treatment of depression among women worldwide. Results: Findings indicate that women consistently experience higher rates of depression than men and are particularly vulnerable to adverse mental health outcomes because of poverty, food insecurity, housing instability, discrimination, gender-based violence, caregiving demands, reproductive transitions, and barriers to healthcare access. The literature further demonstrates that cultural beliefs and social norms shape the expression, recognition, and treatment of depressive symptoms, with many non-Western populations reporting predominantly somatic manifestations of distress. Significant disparities in diagnosis and treatment persist because of stigma, workforce shortages, inadequate funding, and limited mental health infrastructure, particularly in low- and middle-income countries. Evidence supports the use of culturally responsive assessment tools, trauma-informed care, gender-sensitive interventions, and community-based models of care to improve mental health outcomes among women. Conclusion: Addressing the global burden of depression among women requires culturally competent, trauma-informed, and gender-responsive approaches that recognize both depressive symptoms and the broader social determinants of mental health. Improving outcomes will depend on expanding access to mental health services, strengthening the mental health workforce, reducing stigma, and implementing policies that promote health equity across diverse populations and settings.

Keywords: depression, women, global mental health, health equity, social determinants of health, gender inequality, cultural competence, mental health disparities.

INTRODUCTION

Depression is one of the most prevalent mental health disorders worldwide and remains a major contributor to disability, reduced quality of life, and premature mortality (Kirkbride et al., 2024; Malhi et al., 2026). It affects individuals across all age groups, cultures, socioeconomic levels, and geographic regions, impairing emotional, cognitive, social, and occupational functioning. Globally, depression contributes substantially to the burden of disease and is recognized as a significant public health concern requiring coordinated international action (Kirkbride et al., 2024; Malhi et al., 2026). Recent evidence indicates that women bear a disproportionate burden of depression worldwide. Biological influences, reproductive transitions, caregiving responsibilities, gender discrimination, economic inequities, and exposure to gender-based violence contribute to increased vulnerability among women (Alon et al., 2024; Kirkbride et al., 2024).

These factors highlight the importance of culturally sensitive and gender-responsive approaches to assessment, prevention, and treatment of depression globally (Dias et al., 2026). Furthermore, despite growing recognition of mental health as a global priority, substantial disparities remain in access to mental health services, availability of trained providers, and utilization of evidence-based treatment (Kirkbride et al., 2024; World Health Organization [WHO], 2026). Mental health stigma, inadequate healthcare resources, and sociocultural barriers continue to limit diagnosis and treatment, especially in low- and middle-income countries. Therefore, addressing depression requires a comprehensive approach that incorporates biological, psychological, social, cultural, and environmental influences on mental health ([Kirkbride et al., 2024; World Health Organization, 2026).

This article is an integrative review of the literature that explores the role of social determinants of health, including poverty, food insecurity, housing instability, discrimination, social exclusion, migration stress, and exposure to violence, in contributing to depression among women worldwide. Gender-specific factors such as reproductive transitions, caregiving responsibilities, unequal economic opportunities, and gender-based violence are examined as important contributors to women's increased vulnerability to depression across the life course. Despite the availability of effective treatments, substantial global disparities remain in access to mental health services because of stigma, workforce shortages, inadequate funding, and limited healthcare infrastructure, particularly in low- and middle-income countries.

CONCEPTUAL FRAMEWORK OF GLOBAL DEPRESSION IN WOMEN: CULTURAL INFLUENCES, SOCIAL DETERMINANTS, GENDER INEQUALITIES, TREATMENT CHALLENGES, AND IMPLICATIONS FOR HEALTHCARE PRACTICE

The conceptual framework presented in Table 1 guides the organization of this paper. Drawing upon current evidence related to global depression among women, the paper examines five interconnected areas: (1) the incidence and prevalence of depression worldwide; (2) cultural perspectives on depression, including differences in symptom presentation, assessment, and treatment; (3) the role of social determinants of health and gender inequalities; (4) treatment and mental health workforce challenges; and (5) implications for healthcare professionals. Together, these domains provide a comprehensive understanding of the complex biological, social, cultural, and structural factors that contribute to depression among women globally.

Table 1: Conceptual Framework: Global Depression in Women

Major Topic	Subtopic	Description/Relationship to Global Depression in Women
1. Incidence and Prevalence of Depression Worldwide	Global Burden of Depression	Depression is one of the most prevalent mental health disorders worldwide and is a leading cause of disability. Women experience depression at higher rates than men across most countries and age groups.
	Gender Differences in Prevalence	Women are approximately 1.5 times more likely than men to experience depression because of biological, psychological, and social determinants.
2. Cultural Perspectives on Depression Around the Globe	Cultural Differences in the Expression of Depression	Depression may be expressed through emotional symptoms in Western societies and through somatic or physical symptoms in many non-Western cultures.
	Cultural Beliefs About the Causes of Depression	Some cultures view depression as a medical condition, whereas others attribute symptoms to spiritual, religious, moral, social, or family-related causes.
	Cultural Considerations in Assessment	Standardized Western screening tools may fail to identify culturally specific manifestations of depression unless properly translated and validated.
	Cultural Differences in Treatment Approaches	Individuals may seek professional treatment, religious guidance, traditional healers, family support, or community-based services depending on cultural norms.
	Gender-Sensitive Assessment of Depression	Assessment should consider pregnancy, postpartum experiences, menopause, gender-based violence, caregiving roles, poverty, and reproductive health factors.
	Stigma and Help-Seeking Behaviors	Cultural beliefs about mental illness influence help-seeking behavior, treatment adherence, and willingness to access mental health services.
3. Social Determinants and Gender Inequalities	Poverty and Economic Hardship	Financial instability, unemployment, and economic dependence increase the risk of depression and limit access to care.
	Gender-Based Violence and Trauma Exposure	Intimate partner violence, sexual violence, and traumatic experiences significantly increase women's vulnerability to depression.
	Caregiving Burden and Role Strain	Women frequently assume caregiving responsibilities for children, older adults, and family members, increasing stress and emotional burden.
	Discrimination and Social Exclusion	Gender discrimination, unequal opportunities, and social marginalization contribute to depressive symptoms and mental health inequities.
	Reproductive and Hormonal Transitions	Pregnancy, postpartum changes, infertility, perimenopause, and menopause are associated with increased depression risk.
	Availability of Social Support Systems	Strong family, peer, and community support networks may protect against depression and improve recovery outcomes.
	Migration, Displacement, and Acculturation Stress	Refugees, immigrants, and displaced women may experience depression related to cultural adaptation, loss, trauma, and social isolation.
	Housing Instability and Food Insecurity	Lack of stable housing and inadequate food access are associated with increased depression risk and poor mental health outcomes.
	Mental Health Workforce Shortages	Many countries face shortages of psychiatrists, psychologists, counselors, and mental health specialists.
	Access to Care	Geographic barriers, cost, transportation, stigma, and healthcare inequities limit access to mental health services.

	Treatment Gap	A substantial proportion of individuals with depression do not receive timely diagnosis or evidence-based treatment.
	Community-Based Mental Health Services	Community health workers, peer-support programs, women's organizations, and faith-based initiatives help expand access to care.
	Integration into Primary Care	Integrating mental health services into primary care improves access and early identification of depression.
5. Implications for Healthcare Professionals	Culturally Responsive Care	Healthcare professionals should recognize cultural beliefs, values, language differences, and symptom presentations when assessing depression.
	Gender-Informed Assessment	Clinicians should routinely assess gender-specific risk factors and social determinants that influence women's mental health.
	Trauma-Informed Practice	Evaluation should include screening for violence, trauma, abuse, and other adverse life experiences.
	Addressing Social Determinants	Healthcare professionals should assess economic hardship, housing status, food insecurity, discrimination, and social support systems.
	Mental Health Equity	Efforts should focus on reducing disparities, improving access to care, and promoting equitable mental health outcomes for women globally.
	Prevention and Early Intervention	Early identification, education, screening, and culturally appropriate interventions can improve outcomes and reduce the burden of depression worldwide.

This paper is guided by the conceptual framework presented in Table 1, which illustrates the multifactorial influences on depression among women from a global perspective. The framework integrates epidemiological, cultural, social, and healthcare dimensions to examine how depression is experienced, assessed, and treated across diverse populations. The paper is organized into five major sections. First, it examines the incidence and prevalence of depression worldwide, with particular attention to gender differences in disease burden. Second, it explores cultural perspectives on depression, including variations in symptom expression, assessment practices, and treatment approaches across populations. Third, the paper analyzes the influence of social determinants of health and gender inequalities on women's vulnerability to depression. Fourth, it discusses global treatment and mental health workforce challenges that contribute to persistent disparities in access to care. Finally, the paper considers the implications for healthcare professionals, emphasizing the importance of culturally responsive, gender-sensitive, and equity-focused approaches to depression assessment, treatment, and prevention.

INCIDENCE AND PREVALENCE OF DEPRESSION WORLDWIDE

Depression is one of the most common mental health disorders globally (World Health Organization, 2026). According to the World Health Organization, approximately 5.2% of adults worldwide experience depression, representing more than 320 million individuals globally (World Health Organization, 2026). Depression is found in every region of the world regardless of race, ethnicity, culture, or economic status and remains a leading cause of disability worldwide (World Health Organization, 2026).

Significant gender differences exist in the prevalence of depression (World Health Organization, 2026; Kirkbride et al., 2024). Global estimates indicate that women

experience depression at substantially higher rates than men. In 2023, approximately 6.2% of women experienced depression compared with 4.1% of men, making women approximately 1.5 times more likely to develop depressive disorders (Kirkbride et al., 2024; World Health Organization, 2026). These differences emerge during adolescence and continue throughout adulthood, suggesting the influence of both biological and social determinants of mental health.

Women are particularly vulnerable during key reproductive transitions, including pregnancy, the postpartum period, perimenopause, and menopause (Alon et al., 2024; World Health Organization, 2026). Globally, more than 10% of pregnant women and women who have recently given birth experience depression, making perinatal depression a major public health concern. Untreated maternal depression has been associated with adverse outcomes for mothers, infants, families, and communities, with effects extending across generations (Alon et al., 2024; World Health Organization, 2026).

Research further demonstrates that depression is strongly associated with adverse social conditions (Alon et al., 2024; Kirkbride et al., 2024). Individuals experiencing poverty, food insecurity, unemployment, social isolation, discrimination, and inadequate access to healthcare experience significantly higher rates of depressive symptoms and major depressive disorder. Women are disproportionately exposed to many of these risk factors because of persistent gender inequities in education, employment, economic opportunity, caregiving responsibilities, and social status worldwide (Kammer-Kerwick et al., 2024; Kirkbride et al., 2024). Despite the high prevalence of depression, treatment gaps remain substantial worldwide. Many individuals with depression do not receive timely diagnosis or evidence-based treatment because of stigma, shortages of mental health professionals, inadequate funding, and limited access to services. (Kirkbride et al., 2024; World Health Organization, 2026). These disparities are particularly evident in low- and middle-income countries where mental health resources remain scarce. As a result, depression continues to represent one of the most significant contributors to the global burden of disease among women and men across the lifespan.

CULTURAL PERSPECTIVES ON DEPRESSION AROUND THE GLOBE: DIFFERENCES IN SYMPTOMS, ASSESSMENT, AND TREATMENT

Depression is recognized as a common mental disorder across cultures; however, its symptoms, explanatory models, help-seeking behaviors, and treatment pathways vary substantially among populations (Kirmayer & Swartz, 2013; Kleinman, 2004). Because modern diagnostic frameworks such as the DSM-5-TR and ICD-11 were largely developed from research conducted in Western settings, scholars have argued that these classifications may not fully capture culturally specific expressions of distress, particularly in non-Western societies where depression may be manifested through somatic, social, or spiritual experiences rather than psychological symptoms alone (Kirmayer & Swartz, 2013; Kleinman, 2004). Consequently, researchers increasingly emphasize the importance of culturally responsive and gender-sensitive assessment approaches that recognize local beliefs, values, languages, and expressions of emotional distress (Kirkbride et al., 2024; Kirmayer & Swartz, 2013; Kleinman, 2004).

Cultural Differences in the Expression of Depression

One of the most significant cultural differences involves how symptoms of depression are expressed (Kirmayer & Swartz, 2013; Kleinman, 2004). In many Western cultures, depression is commonly identified through psychological symptoms such as sadness, hopelessness, guilt, low self-esteem, loss of pleasure, and emotional distress (Kirmayer & Swartz, 2013; Kleinman, 2004). In contrast, many non-Western cultures tend to express depression through physical or somatic symptoms rather than emotional complaints. Individuals may report fatigue, headaches, dizziness, sleep disturbances, gastrointestinal problems, chronic pain, or generalized body discomfort instead of describing sadness or depressed mood (Kirkbride et al., 2024; Kirmayer & Swartz, 2013; Kleinman, 2004). These cultural variations can create challenges in diagnosis because symptoms may not align with traditional Western diagnostic expectations (Kirmayer & Swartz, 2013; Kirkbride et al., 2024; Kleinman, 2004).

For example, research has demonstrated that many East Asian populations, including Chinese communities, often describe depression through physical symptoms and feelings of internal pressure rather than emotional suffering. Similarly, individuals in African, Latin American, and Indigenous cultures may express distress through bodily symptoms or spiritual explanations (Kirmayer & Swartz, 2013; Kleinman, 2004; Ryder et al., 2002). Research in cultural psychiatry demonstrates that emotional distress is not universally expressed through Western psychological concepts. In many African, Latin American, and Indigenous communities, distress may be interpreted through social relationships, family dynamics, spiritual beliefs, cultural narratives, or physical symptoms rather than through diagnostic categories such as depression. These culturally specific explanatory models influence symptom presentation, help-seeking behaviors, and treatment preferences, highlighting the importance of culturally responsive mental health assessment and intervention (Kirmayer & Swartz, 2013; Kleinman, 2004; Kohrt et al., 2014). Such differences emphasize that depression is not only a biological condition but is also influenced by cultural interpretations of illness and suffering (Kirkbride et al., 2024; Kirmayer & Swartz, 2013; Kleinman, 2004).

Cultural Beliefs About the Causes of Depression

Cultural beliefs strongly influence how depression is understood. In many Western societies, depression is generally viewed as a medical or psychological disorder requiring professional treatment (Kirmayer & Swartz, 2013; Kleinman, 2004; Kohrt et al., 2014). However, other cultures may interpret depression through spiritual, religious, social, or moral frameworks. Some communities view emotional suffering as a normal response to life challenges, while others may attribute symptoms to spiritual imbalances, ancestral influences, or social disharmony (Kirmayer & Swartz, 2013; Kleinman, 2004; Kohrt et al., 2014). These beliefs influence whether individuals seek treatment and from whom they seek help. The role of social determinants is particularly important in understanding cultural differences (Kirmayer & Swartz, 2013; Kleinman, 2004; Kohrt et al., 2014).

Poverty, discrimination, violence, social exclusion, migration, and economic hardship contribute significantly to depression worldwide (Alon et al., 2024; Kirkbride et al., 2024). These factors affect women disproportionately in many societies because of gender inequities and unequal access to resources. Consequently, depression among women often reflects broader social and structural inequalities rather than solely individual psychological factors (Kammer-Kerwick et al., 2024; Kirkbride et al., 2024).

The role of social determinants is particularly important in understanding cultural differences (Alon et al., 2024; Kirkbride et al., 2024). Poverty, discrimination, violence, social exclusion, migration, and economic hardship contribute significantly to depression worldwide (Alon et al., 2024; Kirkbride et al., 2024). These factors affect women disproportionately in many societies because of gender inequities, unequal access to education and employment opportunities, caregiving burdens, and limited access to economic and healthcare resources (Kammer-Kerwick et al., 2024; Kirkbride et al., 2024). Consequently, depression among women often reflects broader social and structural inequalities rather than solely individual psychological factors (Alon et al., 2024; Kammer-Kerwick et al., 2024; Kirkbride et al., 2024).

Cultural Considerations in Assessment

The limitations of applying Western-developed depression scales universally have been widely recognized (Kirmayer & Swartz, 2013; Kleinman, 2004; Kohrt et al., 2014). Standardized screening instruments may fail to capture culturally specific manifestations of depression unless they are properly translated and validated. Researchers therefore advocate for culturally adapted assessment tools that account for differences in language, symptom expression, values, and social expectations (Kirmayer & Swartz, 2013; Kleinman, 2004; Kohrt et al., 2014). In low- and middle-income countries, locally validated screening instruments and community-based mental health approaches are particularly important because cultural differences in symptom expression may increase the risk of underdiagnosis, overdiagnosis, and misdiagnosis when assessment tools are not adapted to local contexts (Kirkbride et al., 2024; Kohrt et al., 2014). Assessment should also consider culturally relevant factors such as family relationships, spirituality, migration experiences, discrimination, social support systems, and gender roles to improve diagnostic accuracy and reduce the risk of misdiagnosis (Kirkbride et al., 2024; Kohrt et al., 2014).

Gender-Sensitive Assessment of Depression

Women experience depression differently than men because of biological, psychological, and social factors (Alon et al., 2024; Kirkbride et al., 2024). Contemporary research recommends that depression assessments incorporate gender-specific experiences such as pregnancy, childbirth, menopause, caregiving responsibilities, intimate partner violence, poverty, discrimination, and reproductive health challenges (Alon et al., 2024; Kirkbride et al., 2024). The recently announced Lancet Psychiatry Commission on Women's Mental Health highlighted the disproportionate burden of mental illness among women and emphasized the need for mental health frameworks that better reflect women's lived experiences (Kammer-Kerwick et al., 2024; World Health Organization, 2026).

Gender-sensitive assessment is particularly important because many women worldwide experience multiple social stressors simultaneously (Alon et al., 2024; Kammer-Kerwick et al., 2024). Economic disadvantage, unequal educational opportunities, caregiving obligations, and gender-based violence are strongly associated with depressive symptoms and may not be adequately captured by traditional screening measures (Alon et al., 2024; Kammer-Kerwick et al., 2024; Kirkbride et al., 2024).

Cultural Differences in Treatment Approaches

Treatment preferences vary substantially across cultures (Kirmayer & Swartz, 2013; Kohrt et al., 2014; Patel, 2001). In many Western countries, individuals commonly seek care from psychiatrists, psychologists, counselors, or primary care providers (Kirmayer & Swartz, 2013; Kohrt et al., 2014; Patel, 2001). Treatment often includes psychotherapy, pharmacological interventions, or a combination of both. In contrast, individuals from many cultural groups may first seek assistance from family members, religious leaders, traditional healers, community elders, or spiritual advisors before consulting mental health professionals (Kirmayer & Swartz, 2013; Kohrt et al., 2014; Patel, 2001).

Community-based interventions have become increasingly important in global mental health initiatives because they align more closely with local cultural values and reduce barriers related to stigma. (Kirkbride et al., 2024; World Health Organization, 2026). Faith-based programs, peer support groups, women's organizations, and community health workers have demonstrated effectiveness in increasing awareness, reducing stigma, and improving access to treatment in underserved populations (Patel et al., 2010; Singla et al., 2017; World Health Organization, 2026).

Stigma and Help-Seeking Behaviors

Mental health stigma remains one of the most significant barriers to treatment globally (Kirmayer & Swartz, 2013; Kohrt et al., 2014). In many cultures, depression may be viewed as a sign of personal weakness, family dishonor, moral failure, or spiritual deficiency (Kirmayer & Swartz, 2013; Kohrt et al., 2014). These beliefs can discourage individuals from seeking professional care and contribute to delays in diagnosis and treatment. Women may face additional barriers because of traditional gender expectations that encourage self-sacrifice, emotional restraint, and caregiving responsibilities (Kirkbride et al., 2024; Kirmayer & Swartz, 2013; Kohrt et al., 2014). Reducing stigma requires culturally appropriate public education, community engagement, and the integration of mental health services into primary care settings. Healthcare providers must demonstrate cultural humility and recognize how cultural beliefs influence symptom presentation, treatment preferences, and healthcare utilization (Kirkbride et al., 2024; Kirmayer & Swartz, 2013; World Health Organization, 2026). As indicated in Table 1, the framework further examines how cultural perspectives shape the expression, interpretation, assessment, and treatment of depression. Cultural beliefs influence symptom presentation, help-seeking behaviors, stigma, and treatment preferences, emphasizing the importance of culturally responsive and gender-sensitive mental health care.

SOCIAL DETERMINANTS AND GENDER INEQUALITIES

Contemporary evidence demonstrates that depression is strongly influenced by social determinants of health, including poverty, food insecurity, unemployment, inadequate housing, social isolation, discrimination, and exposure to violence. These factors contribute significantly to the development and persistence of depressive disorders worldwide (Kirkbride et al., 2024; Lund et al., 2018). Women are disproportionately affected by these adverse social conditions because of persistent gender inequalities in education,

employment, income, access to resources, and social status. As a result, women experience a greater burden of depression globally than men (Kirkbride et al., 2024; Patel et al., 2018).

Recent research has identified food insecurity, loneliness, and social exclusion as important predictors of major depressive disorder (Kammer-Kerwick et al., 2024). In a large study examining social determinants of health and depression, food insecurity and loneliness were strongly associated with increased odds of depression, particularly among women and other marginalized populations (Kammer-Kerwick et al., 2024). Similarly, a comprehensive review of the social determinants of mental health concluded that poverty, social disadvantage, housing instability, discrimination, migration stress, and social isolation significantly increase the risk of depression across the lifespan (Kirkbride et al., 2024).

Gender inequities further contribute to poor mental health outcomes among women (Seedat et al., 2009; World Health Organization, 2000). Globally, women perform the majority of unpaid caregiving responsibilities while simultaneously facing economic inequities and lower earnings compared with men (Seedat et al., 2009; World Health Organization, 2000).

Caregiving responsibilities, workplace stress, unequal pay, and limited economic opportunities have been linked to increased psychological distress and depressive symptoms among women (Seedat et al., 2009; World Health Organization, 2000). Research consistently demonstrates that structural gender inequalities act as fundamental drivers of mental health disparities and are associated with higher rates of depression among women worldwide (Patel et al., 2018; Steel et al., 2014).

Gender-Specific Risk Factors

A substantial body of research supports the relationship between depression and gender-specific biological, psychological, and social experiences (Albert, 2015; Kuehner, 2017). Women are approximately twice as likely as men to experience depression during their lifetime, with increased vulnerability occurring during key reproductive and developmental transitions, including puberty, pregnancy, the postpartum period, perimenopause, menopause, and older adulthood (Salk et al., 2017; Malhi et al., 2026).

The Lancet Psychiatry Commission on Women's Mental Health highlights that women bear a disproportionate burden of mental disorders globally and are approximately 1.5 to 2 times more likely than men to experience depression and anxiety disorders. (Howard et al., 2014; Soares, 2019; World Health Organization, 2026). Biological influences, including hormonal fluctuations and reproductive transitions, interact with social and environmental stressors to increase women's vulnerability to depression across the life course.

Research further demonstrates that intimate partner violence, gender discrimination, caregiving responsibilities, financial insecurity, and unequal access to education and healthcare contribute substantially to depression among women (Devries et al., 2013; Lund et al., 2018).

Women who experience gender-based violence are significantly more likely to develop depressive disorders, anxiety disorders, and other adverse mental health outcomes than women who have not experienced such violence (Devries et al., 2013; Lund et al., 2018). Likewise, caregiving burdens and role strain associated with caring for children, aging

parents, or family members with chronic illnesses increase stress and depressive symptoms among women worldwide (Patel et al., 2018; World Health Organization, 2000).

Women living in low- and middle-income countries often face additional challenges related to poverty, limited educational opportunities, reduced access to healthcare services, and social marginalization (Patel et al., 2018; Steel et al., 2014). These intersecting vulnerabilities contribute to higher rates of depression and poorer mental health outcomes, particularly among women from disadvantaged communities (Patel et al., 2018; Steel et al., 2014).

Research consistently demonstrates that these social determinants contribute significantly to the onset, severity, and persistence of depression worldwide (Alon et al., 2024; Kirkbride et al., 2024). Individuals exposed to adverse social conditions experience substantially higher rates of mental disorders, including depression, anxiety, and psychological distress (Kirkbride et al., 2024; Lund et al., 2018). Furthermore, food insecurity, loneliness, discrimination, and social isolation have been identified as powerful predictors of major depressive disorder among women and marginalized populations (Kammer-Kerwick et al., 2024).

Particular attention should be given to gender-specific contributors to depression. (Alon et al., 2024; Kirkbride et al., 2024). Women experience elevated risk during critical life transitions such as pregnancy, the postpartum period, perimenopause, and menopause (Alon et al., 2024; Kirkbride et al., 2024). Exposure to intimate partner violence, gender discrimination, unequal caregiving expectations, and economic dependency further increase vulnerability to depressive disorders. Consequently, comprehensive mental health assessments should move beyond symptom identification to include screening for psychosocial stressors and social determinants of health (Devries et al., 2013; Salk et al., 2017). These factors are particularly relevant in low- and middle-income countries where women often face multiple intersecting disadvantages. In addition, healthcare organizations should invest in ongoing professional education related to cultural humility, gender-sensitive care, trauma-informed practice, and the social determinants of mental health.

Training programs should help healthcare professionals recognize cultural differences in symptom expression, reduce diagnostic bias, improve communication with diverse populations, and strengthen the delivery of equitable mental health services (Kohrt et al., 2018; McGregor et al., 2019). Such efforts may reduce disparities in diagnosis and treatment while improving patient engagement and adherence to care (Kirkbride et al., 2024; Kohrt et al., 2018). Global mental health experts further emphasize the importance of integrating mental health screening into primary care settings and collaborating with community organizations, women's groups, faith-based organizations, and social service agencies (Patel et al., 2018). Community-centered approaches have been shown to improve access to care, reduce stigma, and promote culturally appropriate interventions for depression, particularly among underserved populations (Kohrt et al., 2018; Patel et al., 2011).

Ultimately, addressing social, cultural, and gender-related determinants of depression can improve early identification, treatment adherence, recovery rates, and overall mental health outcomes among women worldwide (Kammer-Kerwick et al., 2024; Kirkbride et al., 2024). Healthcare professionals who incorporate these considerations into clinical practice are better positioned to advance mental health equity and reduce the

global burden of depression. Table 1 also demonstrates that social determinants of health, including poverty, discrimination, violence, social exclusion, food insecurity, housing instability, and migration-related stress, are important contributors to women's mental health outcomes. Particular attention is given to gender-specific risk factors, such as reproductive and hormonal transitions, caregiving responsibilities, gender-based violence, and unequal access to economic and social resources. These biological, psychological, and social factors frequently interact, increasing women's vulnerability to depression throughout the life course.

TREATMENT AND WORKFORCE CHALLENGES IN GLOBAL DEPRESSION

Although effective treatments for depression are available, substantial treatment gaps persist worldwide (Patel et al., 2018; Thornicroft et al., 2017). Depression remains significantly underdiagnosed and undertreated, particularly in low- and middle-income countries (LMICs), where access to mental health services is often limited by shortages of trained professionals, inadequate health financing, stigma, and insufficient integration of mental health into primary care systems. These barriers disproportionately affect women, rural populations, refugees, displaced persons, and individuals living in poverty (Patel et al., 2018; Thornicroft et al., 2017).

Research indicates that treatment coverage for depression remains low globally despite the availability of effective pharmacological and psychological interventions (Thornicroft et al., 2017). A comprehensive review of global mental health services found that large treatment gaps persist because of workforce shortages, geographic inequalities in service distribution, inadequate infrastructure, and mental health stigma (Thornicroft et al., 2017). Similarly, Vigo et al. (2019) reported that the worldwide burden of mental disorders far exceeds the capacity of existing mental health systems, particularly in resource-constrained settings. The framework also identifies significant treatment and workforce challenges, including shortages of mental health professionals, limited access to services, stigma, and persistent treatment gaps that affect many regions of the world.

Women living in rural communities, humanitarian settings, and low-income regions face additional barriers to treatment (Lund et al., 2018; Patel et al., 2018). Gender inequalities, caregiving responsibilities, limited financial resources, transportation challenges, and exposure to violence can further restrict access to mental healthcare. These social and structural barriers contribute to delayed diagnosis, reduced treatment utilization, and poorer mental health outcomes among women globally (Lund et al., 2018; Patel et al., 2018).

To address workforce shortages and improve access to care, global mental health experts increasingly advocate for task-sharing and task-shifting approaches (Patel et al., 2011; van Ginneken et al., 2013). These models involve training primary care physicians, nurses, community health workers, lay counselors, and peer support specialists to identify, assess, and manage common mental disorders, including depression. Evidence from multiple countries demonstrates that task-sharing interventions can improve access to treatment, reduce symptoms of depression, and expand mental health services in underserved areas (Patel et al., 2011; van Ginneken et al., 2013).

One of the most influential examples is the **MANAS Trial** conducted in India, which demonstrated that lay health counselors working alongside primary care providers significantly improved recovery rates among individuals with depression and anxiety disorders (Patel et al., 2011). Similarly, a systematic review by van Ginneken et al. (2013) found that non-specialist health workers can effectively deliver mental health interventions for depression in low-resource settings.

Researchers have also emphasized the importance of culturally tailored interventions that incorporate local beliefs, traditions, and social support systems (Kohrt et al., 2018; Lund et al., 2018). Community-based programs involving faith leaders, women's organizations, peer support groups, and community health workers have shown promise in reducing stigma and increasing treatment engagement. Such interventions are particularly effective in societies where mental illness may be viewed through spiritual, social, or cultural frameworks rather than solely biomedical perspectives (Kohrt et al., 2018; Lund et al., 2018). Furthermore, strengthening the global mental health workforce remains a critical priority (Patel et al., 2018; Vigo et al., 2019). Expanding mental health education for primary care providers, increasing the availability of psychiatric nurses and mental health specialists, implementing culturally competent care models, and integrating mental health services within universal health coverage initiatives are essential strategies for reducing the global burden of depression. Addressing workforce shortages and treatment disparities is particularly important for improving outcomes among women and other vulnerable populations who experience disproportionate barriers to care (Patel et al., 2018; Vigo et al., 2019; World Health Organization, 2024). In Table 1, these strategies often interact to increase women's vulnerability to depression throughout the life course. The framework also identifies significant treatment and workforce challenges, including shortages of mental health professionals, limited access to services, stigma, and persistent treatment gaps that affect many regions of the world.

IMPLICATIONS FOR HEALTHCARE PROFESSIONALS

Healthcare professionals play a critical role in addressing the global burden of depression among women (Kirkbride et al., 2024; Lund et al., 2018). Contemporary evidence suggests that effective assessment and treatment require a culturally competent, trauma-informed, and gender-responsive approach that recognizes the complex interaction between biological, psychological, social, economic, and cultural determinants of mental health (Kirkbride et al., 2024; Lund et al., 2018). Depression cannot be adequately understood or treated without considering the broader social context in which women live. Women frequently face social and structural inequities that increase their vulnerability to depression, including poverty, gender-based violence, caregiving responsibilities, discrimination, social exclusion, and limited access to healthcare resources (Oram et al., 2017; Vigod & Rockon, 2020; World Health Organization, 2024).

Contributing Factors to Global Mental Health

These factors contribute to the global mental health, social determinants of health, and women's mental health literature. Healthcare professionals should routinely assess women experiencing depressive symptoms for the following risk factors:

- **Poverty and economic hardship:** Poverty is one of the strongest predictors of depression globally. Women living in poverty often experience chronic stress related to meeting basic needs, food insecurity, inadequate housing, unemployment, and limited access to healthcare (Kirkbride et al., 2024; Lund et al., 2018). Financial hardship can reduce a woman's ability to access mental health services, medications, transportation, childcare, and other supportive resources. Research suggests that the relationship between poverty and depression is bidirectional; poverty increases the risk of depression, while depression can worsen economic circumstances through reduced productivity and employment opportunities (Lund et al., 2011; Ridley et al., 2020). Women in low- and middle-income countries are particularly vulnerable because they often experience economic inequality and reduced educational and employment opportunities (Kirkbride et al., 2024; Lund et al., 2018).
- **Gender-based violence and trauma exposure:** Gender-based violence is one of the most significant risk factors for depression among women worldwide (Devries et al., 2013; World Health Organization, 2000). Women exposed to intimate partner violence, sexual assault, childhood abuse, human trafficking, conflict-related violence, or other forms of trauma have substantially higher rates of depression, anxiety, substance abuse, and suicide attempts. Trauma may alter psychological coping mechanisms, increase feelings of helplessness, and contribute to chronic stress responses that affect mental health over time (Devries et al., 2013; World Health Organization, 2000). Healthcare providers should routinely screen for current and past trauma because these experiences often remain undisclosed unless directly assessed.
- **Caregiving burden and role strain:** Women continue to perform the majority of unpaid caregiving worldwide, including caring for children, aging parents, spouses, and family members with chronic illnesses (Dias et al., 2025; Lund et al., 2018).. Many women simultaneously balance employment, childcare, household management, and caregiving duties, resulting in role overload and role conflict (Glynn et al., 2009; Halinski et al., 2020). Chronic caregiving burden has been associated with increased depressive symptoms, emotional exhaustion, sleep disturbances, and decreased quality of life (del-Pino-Casado et al., 2019; Yao et al., 2024). Multiple caregiving responsibilities can create significant emotional, physical, and financial stress. Many women simultaneously balance employment, childcare, household management, and caregiving duties, resulting in role overload and role conflict. Chronic caregiving burden has been associated with increased depressive symptoms, emotional exhaustion, sleep disturbances, and decreased quality of life.
- **Discrimination and social exclusion:** Experiences of discrimination based on gender, race, ethnicity, religion, sexual orientation, disability, immigration status, or socioeconomic status contribute significantly to depression (Kammer-Kerwick et al., Kirkbride et al., 2024). Discrimination creates chronic stress and negatively affects self-esteem, social relationships, economic opportunities, and healthcare access. Social exclusion may lead to isolation, loneliness, reduced community engagement, and diminished social support, all of which are strongly associated with depressive symptoms. depression (Kammer-Kerwick et al., Kirkbride et al., 2024). Women with intersecting marginalized identities often face multiple forms of discrimination that increase their risk of poor mental health outcomes.

- **Reproductive and hormonal transitions:** Women experience several biological transitions that may increase vulnerability to depression (Malhi et al., 2026; Salk et al., 2017). These include puberty, menstruation, pregnancy, postpartum changes, perimenopause, and menopause. Hormonal fluctuations can interact with environmental stressors, social support systems, and individual coping mechanisms to influence mood and mental health. Perinatal depression is particularly important because it affects not only mothers but also infant development, family functioning, and long-term child outcomes (Malhi et al., 2026; Salk et al., 2017). More than 10% of women globally experience depression during pregnancy or after childbirth (Malhi et al., 2026; Salk et al., 2017).
- **Availability of social support systems:** Strong social support is one of the most protective factors against depression (Kirkbride et al., 2024; Kohrt et al., 2018). Family relationships, friendships, faith communities, community organizations, support groups, and positive workplace relationships can buffer stress and improve resilience. Conversely, women who lack social support are more likely to experience loneliness, helplessness, hopelessness, and depressive symptoms (Kirkbride et al., 2024; Kohrt et al., 2018). Assessment should include evaluating the quality and availability of emotional, practical, and financial support.
- **Migration, displacement, and acculturation stress:** Migration, displacement, and acculturation stress—Immigrant, refugee, and displaced women often face unique mental health challenges (Kirkbride et al., 2024; Kohrt et al., 2018). Migration may involve family separation, loss of social networks, language barriers, discrimination, economic hardship, trauma exposure, and difficulties adapting to a new culture. Refugees and displaced populations may have experienced war, violence, persecution, or forced relocation. Migration, displacement, and acculturation stress (Kirkbride et al., 2024; Lund et al., 2018). These experiences increase vulnerability to depression and other mental health disorders. Healthcare providers should assess migration history, acculturation stress, and available support systems.
- **Housing instability and food insecurity:** Stable housing and access to nutritious food are fundamental social determinants of mental health (Kammer-Kerwick et al., 2024; Kirkbride et al., 2018; Lund et al., 2018). Women experiencing housing insecurity, homelessness, overcrowding, or unsafe living conditions often report significantly higher levels of depression and psychological distress. Similarly, food insecurity creates chronic stress related to uncertainty about obtaining adequate nutrition and meeting family needs. (Kammer-Kerwick et al., 2024; Kirkbride et al., 2018; Lund et al., 2018). Research has identified food insecurity as one of the strongest predictors of depression, particularly among women, low-income families, and marginalized populations.

These factors are consistently identified as major contributors to depression among women worldwide and should be incorporated into comprehensive mental health assessments. Healthcare professionals should routinely assess women experiencing depressive symptoms for risk factors such as poverty and economic hardship, gender-based violence and trauma exposure, caregiving burden and role strain, discrimination and social exclusion, reproductive and hormonal transitions, availability of social support systems, migration, displacement, and acculturation stress, housing instability, and food insecurity,

as these factors are strongly associated with the development, persistence, and severity of depression among women globally (Devries et al., 2013; Kammer-Kerwick et al., 2024; Kirkbride et al., 2024; Kohrt et al., 2018; Lund et al., 2018; Salk et al., 2017). Addressing these factors can improve early diagnosis, treatment adherence, and overall mental health outcomes for women.

Furthermore, healthcare organizations should invest in ongoing education regarding cultural humility, gender-sensitive care, trauma-informed practice, and the social determinants of mental health to reduce disparities in depression diagnosis and treatment (Kirkbride et al., 2024; Kohrt et al., 2018; Lund et al., 2018). Finally, Table 1 outlines implications for healthcare professionals, emphasizing the need for culturally informed, trauma-informed, and gender-responsive approaches to assessment, prevention, and intervention. Overall, the framework demonstrates that improving global mental health among women requires addressing both clinical symptoms and the broader social, cultural, and structural conditions that influence mental health equity and well-being.

CONCLUSION

Depression is a global health concern that transcends cultural boundaries, yet its expression, interpretation, and treatment vary significantly around the world. Western models emphasize emotional symptoms, whereas many non-Western cultures express depression through somatic complaints, spiritual concerns, or social distress. Cultural beliefs influence help-seeking behaviors, treatment preferences, and attitudes toward mental illness. Therefore, healthcare professionals must utilize culturally responsive and gender-sensitive assessment tools and interventions to effectively identify and treat depression, particularly among women and other vulnerable populations. Understanding these cultural differences is essential for reducing disparities in diagnosis and improving treatment outcomes.

REFERENCES

1. Albert PR. Why is depression more prevalent in women? *J Psychiatry Neurosci*. 2015;40(4):219-221. doi:10.1503/jpn.150205.
2. Alon N, Macrynika N, Jester DJ, Keshavan M, Reynolds CF 3rd, Saxena S, Thomas ML, Torous J, Jeste DV. Social determinants of mental health in major depressive disorder: Umbrella review of 26 meta-analyses and systematic reviews. *Psychiatry Res*. 2024;335:115854. doi:10.1016/j.psychres.2024.115854.
3. del-Pino-Casado R, Rodríguez Cardosa M, López-Martínez C, Orgeta V. The association between subjective caregiver burden and depressive symptoms in carers of older relatives: A systematic review and meta-analysis. *PLOS ONE*. 2019;14(5):e0217648.
4. Devries KM, Mak JYT, Bacchus LJ, Child JC, Falder G, Petzold M, Astbury J, Watts CH. Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies. *PLoS Med*. 2013;10(5):e1001439. doi:10.1371/journal.pmed.1001439.
5. Dias MC, Van Den Noortgate M, Høgsted ES, Womersley K, Spicer A, Chandra PS, et al. Announcing the Lancet Psychiatry Commission on women's mental health: A new era for mental health. *Lancet Psychiatry*. 2026;13(4):283-285.

6. Glynn K, Maclean H, Forte T, Cohen M. The association between role overload and women's mental health. *Journal of Women's Health*. 2009;18(2):217-223.
7. Halinski M, Duxbury L, Stevenson M. Employed caregivers' response to family-role overload: The role of control-at-home and caregiver type. *Journal of Business and Psychology*. 2020;35:99-115.
8. Howard LM, Molyneaux E, Dennis CL, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. *Lancet*. 2014;384(9956):1775-1788. doi:10.1016/S0140-6736(14)61276-9.
9. Kammer-Kerwick M, Cox K, Purohit I, Watkins SC. The role of social determinants of health in mental health: An examination of the moderating effects of race, ethnicity, and gender on depression through the All of Us Research Program dataset. *PLoS Ment Health*. 2024;1(3):e0000015. doi:10.1371/journal.pmen.0000015.
10. Kirkbride JB, Anglin D, Colman I, Dykxhoorn J, Jones PB, Patalay P, Pitman A, Sonesson E, Steare T, Wright T, Griffiths SL. The social determinants of mental health and disorder: Evidence, prevention and recommendations. *World Psychiatry*. 2024;23(1):58-90. doi:10.1002/wps.21160.
11. Kirmayer LJ, Swartz L. Culture and global mental health. In: Patel V, Minas H, Cohen A, Prince MJ, editors. *Global Mental Health: Principles and Practice*. Oxford: Oxford University Press; 2013. p. 41-62.
12. Kleinman A. Culture and depression. *N Engl J Med*. 2004;351(10):951-953. doi:10.1056/NEJMp048078.
13. Kohrt BA, Asher L, Bhardwaj A, Fazel M, Jordans MJD, Mutamba BB, Nadkarni A, Pedersen GA, Singla DR, Patel V. The role of communities in mental health care in low- and middle-income countries: A meta-review of components and competencies. *Int J Environ Res Public Health*. 2018;15(6):1279. doi:10.3390/ijerph15061279.
14. Kuehner C. Why is depression more common among women than among men? *Lancet Psychiatry*. 2017;4(2):146-158. doi:10.1016/S2215-0366(16)30263-2.
15. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, Chandra P, Haushofer J, Herrman H, Jordans MJD, Kieling C, Medina-Mora ME, Morgan E, Omigbodun O, Tol W, Patel V, Saxena S. Social determinants of mental disorders and the Sustainable Development Goals: A systematic review of reviews. *Lancet Psychiatry*. 2018;5(4):357-369. doi:10.1016/S2215-0366(18)30060-9.
16. Malhi GS, Bell E, Stavdal A, Wu CY, Naylor A, Kumari V. Depression. *Lancet*. 2026;407(10540):1738-1756.
17. McGregor B, Belton A, Henry TL, Wrenn G, Holden KB. Improving behavioral health equity through cultural competence training of health care providers. *Ethnicity & Disease*. 2019;29(Suppl 2):359-364. doi:10.18865/ed.29.S2.359.
18. Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *Lancet Psychiatry*. 2017;4(2):159-170. doi:10.1016/S2215-0366(16)30261-9.
19. Patel V. Cultural factors and international epidemiology. *Br Med Bull*. 2001;57(1):33-45. doi:10.1093/bmb/57.1.33.
20. Patel V, Lund C, Hatherill S, Plagerson S, Corrigan J, Funk M, Flisher AJ, Saxena S. Mental disorders: Equity and social determinants. In: Blas E, Sivasankara Kurup A, editors. *Equity, Social Determinants and Public Health Programmes*. Geneva: World Health Organization; 2010. p. 115-134.
21. Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, De Silva MJ, Bhat B, Araya R, King M, Simon G, Verdelli H. Effectiveness of an intervention led by lay health counsellors for

- depressive and anxiety disorders in primary care in India (MANAS): A cluster randomized controlled trial. *Lancet*. 2010;376(9758):2086-2095. doi:10.1016/S0140-6736(10)61508-5.
22. Ridley M, Rao G, Schilbach F, Patel V. Poverty, depression, and anxiety: Causal evidence and mechanisms. *Science*. 2020;370(6522):eaay0214. doi:10.1126/science.aay0214.
 23. Ryder AG, Yang J, Heine SJ. Somatization vs. psychologization of emotional distress: A paradigmatic example for cultural psychopathology. *Online Read Psychol Cult*. 2002;10(2). doi:10.9707/2307-0919.1071.
 24. Salk RH, Hyde JS, Abramson LY. Gender differences in depression in representative national samples: Meta-analyses of diagnoses and symptoms. *Psychol Bull*. 2017;143(8):783-822. doi:10.1037/bul0000102.
 25. Seedat S, Scott KM, Angermeyer MC, Berglund P, Bromet EJ, Brugha TS, Demyttenaere K, de Girolamo G, Haro JM, Jin R, Karam EG, Kovess-Masfety V, Levinson D, Medina-Mora ME, Ono Y, Ormel J, Pennell BE, Posada-Villa J, Sampson NA, Kessler RC. Cross-national associations between gender and mental disorders in the World Health Organization World Mental Health Surveys. *Arch Gen Psychiatry*. 2009;66(7):785-795. doi:10.1001/archgenpsychiatry.2009.36.
 26. Singla DR, Kohrt BA, Murray LK, Anand A, Chorpita BF, Patel V. Psychological treatments for the world: Lessons from low- and middle-income countries. *Annu Rev Clin Psychol*. 2017;13:149-181. doi:10.1146/annurev-clinpsy-032816-045217.
 27. Soares CN. Depression and menopause: An update on current knowledge and clinical management for this critical window. *Med Clin North Am*. 2019;103(4):651-667. doi:10.1016/j.mcna.2019.03.001.
 28. Steel Z, Marnane C, Iranpour C, Chey T, Jackson JW, Patel V, Silove D. The global prevalence of common mental disorders: A systematic review and meta-analysis, 1980-2013. *Int J Epidemiol*. 2014;43(2):476-493. doi:10.1093/ije/dyu038.
 29. Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, Al-Hamzawi A, Alonso J, Andrade L, Borges G, Bruffaerts R, et al. Undertreatment of people with major depressive disorder in 21 countries. *Br J Psychiatry*. 2017;210(2):119-124. doi:10.1192/bjp.bp.116.188078.
 30. van Ginneken N, Tharyan P, Lewin S, Rao GN, Meera SM, Pian J, Chandrashekar S, Patel V. Non-specialist health worker interventions for mental health care in low- and middle-income countries. *Cochrane Database Syst Rev*. 2013;(11):CD009149. doi:10.1002/14651858.CD009149.pub2.
 31. Vigo D, Thornicroft G, Atun R. Estimating the true global burden of mental illness. *Lancet Psychiatry*. 2019;6(2):171-178. doi:10.1016/S2215-0366(18)30479-0.
 32. Vigod SN, Rochon PA. The impact of gender discrimination on a woman's mental health. *EClinicalMedicine*. 2020;20:100311. doi:10.1016/j.eclinm.2020.100311.
 33. World Health Organization. Women's Mental Health: An Evidence-Based Review. Geneva: World Health Organization; 2000.
 34. World Health Organization. Fair share for health and care: gender and the undervaluation of health and care work. Geneva (CH): World Health Organization; 2024.
 35. World Health Organization. Depressive Disorder (Depression). Geneva: World Health Organization; 2026.
 36. Yao H, Li K, Li C, et al. Caregiving burden, depression, and anxiety in informal caregivers of people with mental illness in China: A cross-sectional survey. *BMC Psychiatry*. 2024;24:824.