Limitations of Research in Predominant Female Disorders and Mental Services:

The USA and the Dominican Republic

Ericka Vargas

University of Florida

Limitations of Research in Predominant Female Disorders and Mental Services: The USA and the Dominican Republic

There is the common knowledge that females make up the predominant population for mild psychological disorders, and that there are different trends in different countries. Yet, there is no real focus on the literature that addresses with a broad approach the predominant disorders and services in respect to gender in each country. As stated by the World Health Organization (WHO), culturally and/or socially sensitive research that explores the gender gap in mental health disorders is highly needed (2014). In fact, research that studies female predominant psychological disorders pertaining to cultures is weak, and therefore necessary to identify the trends and factors that contribute to female mental distress and the needs and services that can be provided to them. The rationale is that if there is gap in the literature, then there is neglect in the needs of the female population's mental health, and an obstacle for the implementation of solutions. Therein, this review is meant to evaluate the limitations in the existing literature and research regarding the predominant female disorders and mental health services provided to the female population in the USA and the Dominican Republic. Consequently, this is a conglomeration of research and evidence available of predominant female psychological disorders in these two countries, and the mental services provided to the general female population. By exploring the research that focuses on females, their disorders, and the demographic it pays attention, will allow improvements each country can make to enhance their services and understanding of such disorders to be proposed.

The female population is deemed to be very susceptible and vulnerable to common mental health disorders besides constituting the main population diagnosed with such mental disorders (WHO, 2014), and as a matter of fact they need to be paid attention. Regarding the Dominican

Republic, the research and resources available is very limited to psychosomatic or strictly somatic factors, such as lymphatic filiarasis (elephant leg) and HIV/AIDS. The research and literature published here is very limited, and not recorded with much detail to gender. Accordingly, due to the lack of true literature in the Dominican Republic, this review will by necessity mainly focus in its limitations and suggested improvements.

Sequence of the review will be as such: go in detail for each country's: a) data available about major prominent female disorders b) trends in mental services provided and used c) limitations and improvements regarding the research and information available about the main female disorders and the services provided.

1) USA overview
    - Main disorders
    - Services
    - Gaps/improvements
2) Dominican Rep. overview
    - White paper/disorders studied
    - Services
    - Gaps/Improvements

United States of America's Overview

Predominant Disorders:

In the United States' population, women are most likely than men to be diagnosed with any mental illness (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013a). The prominent disorders that the female population is suggested to be diagnosed in order of highest predominance are: 1) Major Depressive disorders, 2) Anxiety disorders, and 3) Eating disorders. Women ranked with an 8.4% prevalence of having had a Major Depressive episode in the past year with almost a two-fold lead over men (SAMHSA, 2013h). Plus, young females are the leading demographic with this disorder in the youth population (SAMHSA, 2013i). According, to the National Comorbidity Survey, major depression alone is the leading disorder for females (20.6% of the female population affected); and the conglomeration of anxiety disorders (for example, phobias, panic disorder, post-traumatic stress disorder, etc) affects 36% of the female population (Harvard Medical School, 2007). Yet, it can be deduced that major depression is the main disorder that affects women because it being a single disorder affects a significant portion of the population−compared to the multiple sub-disorders that make up the anxiety disorders umbrella. Moreover, Women also dominate the statistic with eating disorders, having a three-fold lead over men in anorexia, bulimia, and 75% more likely than men to engage in binge-eating (National Institute of Mental Health, n.d.);binge-eating being the main disorder that affects women (Kessler, et al., 2013, p. 906).

Mental Services:

According to the Results from the 2012 National Survey on Drug Use and Health administered by the US department of health and human services, "among adults aged 18 or

older in 2012, women were more likely than men to use mental health services in the past year (18.6 vs. 10.2 percent)" (SAMHSA, 2013c). The mental health services provided and mainly used are as followed: prescription medication (highest with a 15.9% of females using this treatment method) (SAMHSA, 2013e); outpatient mental health services used by about 8.6% of the female adult population and females are the main out-patient population (SAMHSA, 2013d; WHO, 2011b, p.4). Furthermore, the main mental professionals that assist the general female population in order of most used are: Office of a Private Therapist, Psychologist, Psychiatrist, Social Worker, or Counselor – Not Part of a Clinic, Outpatient Mental Health Clinic/Center professionals, and Doctor's Office - Not Part of a Clinic (SAMHSA, 2013f).

Limitations:

It is a great benefit to have the data that suggests the needs of certain populations, and what affects them. USA's data allows for further investigation of the mental health disorders, factors, and mental health services that exist in the female population. Yet, there are limitations that need to be addressed and improvements to be made.

- The country needs more clear data regarding gender-based disorders; the data should be more organized by main disorders and services pertaining to women, men, ethnicities, sexuality, and so on.
- Data collection sample does not include foreign language-speakers that do not speak English and Spanish (SAMHSA, 2013b); data that excludes them is not representative since they are part of the US society and exposed to its societal conditions. There should be more inclusiveness in regards to language other than English and Spanish and culture sensitive measurements.

- As observed, data on general mental services and access to care for the general population (both men and women) exists, but there is limited research on what is provided only for each gender/sex; gender specific data on admissions to certain treatment facilities and therapy is weak and with several gaps on what is provided, and evidence is limited about the mental health professional workforce available even for the population (WHO, 2011b, p. 3). Therein, no conclusions about the female population can be deduced.
- There is a high unmet need for mental health treatment in the female population (SAMHSA, 2013g). This suggests that the population is not receiving an effective treatment, thus enhanced treatments that explore gender-specific, cultural, and social factors might be a good course of action. Accordingly, the factors that affect the female population should be studied in order to synthesize an appropriate treatment; every society, ethnicity, gender, and economic class has different internal and external forces that act upon them to manifest mental disorders, therefore these forces or factors can expose what needs to be worked on.

Dominican Republic's Overview

Predominant Disorders:

The minimal data available about psychological disorders in females suggests that they are affected by mood disorders and Schizophrenia. This is not a reliable assumption, but it is suggested that in mental hospitals the majority of patients (approximately 54%) are females, and the main disorders that are treated for patients (both men and women) are mood disorders (69%) and Schizophrenia (21%) (State Secretariat of Public Health and Social Assistance [SESPAS],

Pan American Health Organization [PAHO/WHO], & WHO Department of Mental Health and Substance Abuse [MSD], 2008, p. 19). Subsequently, not much was found regarding these disorders. In fact, the popular studies the literature search highlighted a trend in psychosomatic disorders and their psychological and mental consequences in women. The research is focused on women's medical and corporeal maladies and then the psychological factors that are related to those illnesses. The only psychological focus in those studies is the mental distress caused by psychosomatic disorders and/or medical disorders such as lymphatic filariasis (elephant leg) and their susceptibility to HIV/AIDS. However, this is clearly not a psychological domain where clear mental disorders are assessed. To the contrary, instead of focusing in the psychological realm of these, there is a focus in medical disorders and the correlates of psychological implications as a result of their distress.

The Research highlighted the psychological effects of elephant leg in Dominican women such as social stigma, and coping mechanisms they used (Person, Bartholomew, Gyapong, Addiss, & Van den Borne, 2009, pp. 32-34). This medical disorder "compromised functional abilities, loss of work and increased economic burdens, diminished social roles and social identity, and psychological distress" (Person et al., 2007, p. 91). Although there is no clear statistic that states that elephant leg is a major psychological concern in the female population, this is an area that has numerous studies. Therefore, the fact that this is an area that females' mental well-being seems to have a priority and a high prevalence cannot be ignored. Regarding HIV/AIDS, this is also a female-dominated area of study; here psychologists and counseling therapy are highly used (Rutenberg & Baek, 2005, p. 238). Moreover, the allocation of mental health services is promoted in the prevention and follow-up of treatments for HIV/AIDS (Barrington, Moreno, & Kerrigan, 2007, p. 871). Although these are not reliable measurements

that signal the general epidemiology and prevalence of female psychological disorders they are in turn is the closest evidence of psychological needs of certain women.

Mental Services:

The Public Health Minister allied with SESPAS, PAHO/WHO and MSD states that the main resources and services provided to the general population are as follows: 1) day treatment facilities (in which 64% are female) (p.17); 2) in-patient psychiatric facilities in general hospitals in which approximately "55% of the users are females" (p.18); 3) mental hospitals were females make up 54% of the patients (p.19), and 4) out-patient facilities available where the predominant audience is diagnosed with affective mood disorder and/or schizophrenia (p.17). And although there is no data on female population regarding out-patient facilities, one must reflect in the possibility that the percentage of females with mood disorders and schizophrenia in in-patient units and mental hospitals could also apply here. At last, it is also noted that "Casas de Acogida"(charitable houses) specialized in providing resources and psychological support for women are also available (Ministero de la Mujer, 2013, p. 6)[1]; but, the percentage of women that use those are not stated.

Further, data that tracks what type of mental health professionals females seek is not available. One can assume that they seek the mental professionals at the mental hospitals, and in-patient and/or out-patient facilities. But, the data is not available in a clear form or format. The main professionals used for the general population are psychologists and psychiatrists (WHO, 2011a, p. 4). There is also the mention of medically trained physician and indigenous healers as

[1] In the webpage (http://www.mujer.gob.do/servicios.html#) the two documents *Sericios que ofrece el Ministerio de la Mujer* and *Organizaciones no Gubernamentales que reciben apoyo del Estado a través del MMujer* go in further detail and list these charitable organizations that are shelter/support houses.

an important source of mental healing regarding extreme distress (Person et al., 2006, p. 5), yet this was mentioned for elephant leg only.

Limitations:

It is clear that the Dominican Republic has a different approach to psychology influenced by cultural and historical factors such as predominant European and African presences. It has different cultural milestones and intakes of psychology that affect its mental health landscape that need to be explored such as dengue epidemics, higher HIV rates, and higher mortality rates. Nevertheless, this does not justify the lack of research in mental health addressing the population as a whole. If there is no attention paid to the nation's mental health, then there is no real progress helping specific demographics' mental health needs.

- Lack of general record-keeping in mental health and even less pertaining only to women should be addressed (WHO, 2011a, p. 5). And although the mental services exist, the record of female tendencies and patterns in these services are not detailed (WHO, 2011a). Indeed, in the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) report of the country it is admitted that "facilities report most of the data per conglomerate, which prevents accessing timely information on mental health morbidity per group, gender and diagnosis" and that mental health is an "area of major weakness in the country" SESPAS, PAHO/WHO, & MSD, 2008, p. 13). The country's lack of record-keeping hinders the ability to understand the trends in female disorders, the services offered, and most importantly, the ones received by the female population. No resource websites were found that contain meaningful information concerning the prevalence of female disorders. Indeed, the official government mental health website

(http://msp.gob.do/direccion-general-de-salud-mental) offered no information or resources regarding the population's mental health. Consequently, since no record and clear patterns in the previous general umbrella milestones exists (i.e., mental services and predominant disorders), then no real clear and concrete pattern for action and mental services). Since there is minimal information or resources regarding the main female disorders, no action can be taken to develop efficient strategies to tackle these problems. Indeed, WHO-AIMS tries to solve this lack of data by trying to implement a baseline for the main problems (such as the fact that there is minimal data available) in order to propose start points for action and intervention(SESPAS, PAHO/WHO, & MSD 2008, pp. 38-40). But, there is no data that follows up with this program.

- Little to no data is available of actual psychological disorders regarding the female population; in their case, there seems to be a dependence on body in order to treat the mind. Therein, the focus revolves on medical health studies, and few or none in psychological disorders such as depression, anxiety, eating behaviors, spiritual manifestations, etc. For example, popular studies in Elephant leg and HIV do not yield insightful psychological factors independently, rather a trust in the factors (i.e., medical disorders or diseases) that affect these women's emotional well-being. There is a fine line between mental health disorders and general emotional distress. Despite both being extremely important to understand the sociocultural factors that affect women, mental health disorders can signal areas that women are mainly affected and vulnerable to. "The relationship of women's reproductive functioning to their mental health has received protracted and intense scrutiny over many years while other areas of women's health have been neglected" (Department of Mental Health and Substance Dependence [MSD], 2014,

p. 8); this is witnessed in the promotion of women's mental health through prevention and treatment of HIV/AIDS, and lack of research in psychological factors.

- Main target audience is the elderly; not as much focus in the youth and the middle-aged female population. In fact, this is apparent when "only 4% of outpatient services are directed towards mental health care of children and adolescents and there are no children/adolescent inpatient units or forensic psychiatric units in the country" (SESPAS, PAHO/WHO, & MSD, 2008, p. 11)
- Low resource funding for mental health, with "…less than1% (0.38%) of health care expenditures to mental health services," and 50% of the budget going towards one mental hospital (SESPAS, PAHO/WHO, & MSD 2008, pp. 10-11). And, as it was addressed in the North American launch of a special journal series on global mental health in 2007, "the relatively low priority assigned to mental health on the public health policy agenda and, as a result, low funding" (The Lancet, 2007). As arduous as it may be to collect financial support to conduct these studies and data recompilation, it is necessary to allocate resources in this area as it ensures the mental well-being and priority of the people.
- Most importantly, there is "no regular training programs on mental health are developed for primary care staff" (SESPAS, PAHO/WHO, & MSD 2008, p.12). This should be changed because it can lead to outdated and un-proficient staff that can further oppress and neglect the population that is in need of mental health services.
- Regarding the literature there is definitely an abstract trend in psychological disorders in the female population, yet it is mainly in individual studies that are spread in specific regions, samples, and regarding narrow cases. More studies that investigate other areas in

the mental health domain or simply different ways that the population experiences distress should be done.

- The WHO-AIMS program, whose purpose is to implement a baseline for further improvement in the Dominican Republic's mental health system, is in place but again no data that tracks progress is available (SESPAS, PAHO/WHO, & MSD 2008, pp. 37-39). There is a need for implementation of mental health plans and the enforcement of the programs that were stated, plus the availability of current data assessing those plans.

Conclusion

It is a priority to clarify that the purpose of this Literature Review is to point out the areas in female research regarding predominant psychological disorders and services that lag in further research in each country. Each country has its own sociocultural and political factors and strategies that affect the way that female mental disorders are addressed (which in part are not included here). And rather than to compare both of them, this review is meant to juxtapose the information available for both. Each country has its priorities and related agendas, and that is much respected, but the female population should not be forgotten since that would entail neglecting the mental well-being of more than half of the population for both countries.

It seems that although both countries are very different, there seems to still be the similar female disorders trends (mood disorders, and somatic). Yet, each country also has its own milestones to reach and obstacles to overcome. Holistically, The US needs more inclusive and representative strategies to investigate female mental disorders, and the Dominican Republic requires a better record-keeping practice.

The WHO organization served as a great source of information to go about each country's status regarding the general approach to gender research. Yet, much needs to be done, and specifically for the USA and the Dominican Republic as previously mentioned. According to the MSD, in order "…to reduce gender disparities in mental health treatment, gender sensitive services are essential" (p.10), and "to address gender disparities in mental health requires action at many levels" (p. 19). This is the logic to improve the efficacy and inclusiveness of data collection in order to implement services and programs that benefit the needs of the population. The services and programs that need to be implemented must be aware of the cultural, socioeconomic, and biological factors that affect the female population to insure good services since "services must be tailored to meet their needs" (MSD, 2014, p. 10).

"Gender has significant explanatory power regarding differential susceptibility and exposure to mental health risks and differences in mental health outcomes"(WHO, 2014). This explains the need for research and data availability in Dominican Republic, and enhanced sampling and equal inclusion of ethnicities, socioeconomic status, and gender in the USA; in order to aid the population there should be qualitative or quantitative support in order to allocate and assess the needs of such population. Yet, previous findings suggest that women have been subjected to these same disorders for a prolonged time (Dennerstein, Astbury, & Morse, 1993, p. 7). This repetitive trend demonstrates that women's conditions and contributing mental health factors have not changed. There is a lingering social phenomenon that reinforces this gender gap; this could be explained by gender inequality in economic, political, cultural, and interpersonal spheres.

There are limitations in the improvements suggested due to the neglect of other social, economic, and political factors in each country that have a toll in the allocation of their

resources. Yet, they consist of important steps to consider for the enrichment of the mental health area that can increase the quality of life in each nation.Both countries need improvement in their profile-keeping and records regarding female disorders, the mental services provided, and the demographics that they serve. The general record of psychological disorders, services, and factors exists, but with poor attention to females. It is a matter of keeping the research flowing and allocating resources to target this situation.

Indeed, WHO stresses the need to "build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors" (2014), and this shows why these two countries should expand and improve their research in this area.

References

Barrington, C., Moreno, L., & Kerrigan, D. (2007, August). Local understanding of an HIV vaccine and its relationship with HIV-related stigma in the Dominican Republic [Abstract]. *AIDS Care, 19(7),* 871-877. doi:10.1080/09540120701203295

Dennerstein, L., Astbury, J., & Morse, C. (1993). Psychosocial and Mental Health Aspects of Women's Health. Geneva, Switzerland: World Health Organization. Retrieved from http://whqlibdoc.who.int/hq/1993/WHO_FHE_MNH_93.1.pdf?ua=1

Department of Mental Health and Substance Dependence. (2014). Gender disparities in mental health. Retrieved from http://www.who.int/mental_health/media/en/242.pdf?ua=1

Harvard Medical School. (2007, July 19). NCS-R Lifetime prevalence estimates. Retrieved from National Comorbidity Survey (NCS: http://www.hcp.med.harvard.edu/ncs/ftpdir/NCS-R_Lifetime_Prevalence_Estimates.pdf

Kessler, R. C., Berglund, P. A., Chiu, W. T., Deitz, A. C., Hudson, J. I., Shahly, V., . . . Xavier, M. (2013, May 1). The prevalence and correlates of binge eating disorder in the World Health Organization world mental health surveys. *Biological Psychiatry, 73(9*), 904-914. doi:10.1016/j.biopsych.2012.11.020

Ministerio de la Mujer. (2014, January 3). *Sericios que ofrece el Ministerio de la Mujer*. Retrieved from Ministerio de la Mujer: http://www.mujer.gob.do/servicios.html#

Ministero de la Mujer. (2013, December 5*). Organizaciones no Gubernamentales que reciben apoyo del Estado a través del MMujer*. Retrieved from Ministerios de la Mujer: http://www.mujer.gob.do/servicios.html

Ministerio de Salud Publica. (n.d.). *Dirección general de salud mental*. Retrieved from Ministerio de Salud Publica: http://msp.gob.do/direccion-general-de-salud-mental

National Institute of Mental Health. (n.d.). Eating Disorders. *The numbers count: Mental disorders in America*. Retrieved from NIH: http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml#Eating

Person, B., Addiss, D. G., Bartholomew, L. K., Meijer, C., Pou, V., & Van den Borne, B. (2006, December 22). Health-seeking behaviors and self-care practices of Dominican women with lymphoedema of the leg: implications for lymphoedema management programs. *Filaria Journal, 5(13*). doi:10.1186/1475-2883-5-13

Person, B., Addiss, D. G., Bartholomew, L. K., Meijer, C., Pou, V., Guillermo, G., & Van den Borne, B. (2007, August). A qualitative study of the psychosocial and health consequences associated with lymphedema among women in the Dominican Republic. *Acta Tropica, 103(2),* 90-97. doi:10.1016/j.actatropica.2007.05.010

Person, B., Bartholomew, L., Gyapong, M., Addiss, D. G., & Van den Borne, B. (2009, January). Health-related stigma among women with lymphatic filariasis from the Dominican Republic and Ghana. *Social Science & Medicine, 68(1),* 30-38. doi:10.1016/j.socscimed.2008.09.040

Rutenberg, N., & Baek, C. (2005, September). Field experiences integrating family planning into programs to prevent mother-to-child transmission of HIV. *Studies in Family Planning, 36(*3), 235-245. Retrieved from http://www.jstor.org/stable/4148949

Substance Abuse and Mental Health Services Administration. (2013a, December 20). Any mental illness. *In Results from the 2012 national survey on drug use and health: Mental health finding*s (Mental illness and mental health service utilization among adults) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm#sec2-1

Substance Abuse and Mental Health Services Administration. (2013b, December 20). [Appendix]. Data collection methodology. In *Results from the 2012 national survey on drug use and health: Summary of national findings* (Description of the survey) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2012SummNatFindDetTables/NationalFindings/NSDUHresults2012.htm#A.2

Substance Abuse and Mental Health Services Administration. (2013c, December 20). Mental health service utilization among adults. In *Results from the 2012 national survey on drug use and health: Mental health findings* (Mental illness and mental health service utilization among adults) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/2K12MHF/NSDUHmhfr2012.htm#sec2-4

Substance Abuse and Mental Health Services Administration. (2013d, December 20). [Table]. Table 1.27B – received outpatient mental health treatment/counseling in the past year among persons aged 18 or older, by past year level of mental illness, demographic

characteristics, and health characteristics: percentages, 2011 and 2012. *In Results from the 2012 national survey on drug use and health: Mental health detailed tables* (Adult mental health tables - 1.1 to 1.78 (prevalence estimates)) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm#Tab1.27B

Substance Abuse and Mental Health Services Administration. (2013e, December 20). [Table]. Table 1.28B – received prescription medication as a type of mental health treatment/counseling in the past year among persons aged 18 or older, by past year level of mental illness, demographic characteristics, and health characteristics: percentages, 2011 and 2012. In *Results from the 2012 national survey on drug use and health: Mental health detailed tables* (Adult mental health tables - 1.1 to 1.78 (prevalence estimates)) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm#Tab1.28B

Substance Abuse and Mental Health Services Administration. (2013f, December 20). [Table]. Table 1.35B – location of outpatient mental health treatment/counseling among persons aged 18 or older who received outpatient mental health treatment in the past year, by age group: percentages, 2011 and 2012. In *Results from the 2012 national survey on drug use and health: Mental health detailed tables* (Adult mental health tables - 1.1 to 1.78 (prevalence estimates)) (HHS Publication No. (SMA) 13-4795).Retrieved from SAMHSA:

http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm#Tab1.35B

Substance Abuse and Mental Health Services Administration. (2013g, December 20). [Table]. Table 1.41B – Unmet Need for Mental Health Treatment/Counseling in the Past Year among Persons Aged 18 or Older with Past Year Serious Mental Illness, by Receipt of Past Year Mental Health Treatment/Counseling and Demographic Characteristics: Percentages, 2011 and 2012. In *Results from the 2012 national survey on drug use and health: Mental health detailed tables* (Adult mental health tables - 1.1 to 1.78 (prevalence estimates)) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm#Tab1.41B

Substance Abuse and Mental Health Services Administration. (2013h, December 20). [Table]. Table 1.76B – Major Depressive Episode (MDE) in the Past Year among Persons Aged 18 or Older, by Demographic Characteristics: Percentages, 2005-2012. In *Results from the 2012 national survey on drug use and health: Mental health detailed tables* (Adult mental health tables - 1.1 to 1.78 (prevalence estimates)) (HHS Publication No. (SMA) 13-4795).Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect1peTabs2012.htm#Tab1.76B

Substance Abuse and Mental Health Services Administration. (2013i, December 20). [Table]. Table 2.6B – Had at Least One Major Depressive Episode (MDE) or MDE with Severe Impairment in the Past Year among Persons Aged 12 to 17, and Receipt of Treatment for

Depression in the Past Year among Persons Aged 12 to 17 with MDE or MDE with Severe Impairment in the Past Year, by Gender and Detailed Age Category: Percentages, 2011 and 2012. In *Results from the 2012 National Survey on Drug Use and Health: Mental Health Detailed Tables* (Youth Mental Health Tables - 2.1 to 2.14 (Prevalence Estimates)) (HHS Publication No. (SMA) 13-4795). Retrieved from SAMHSA: http://www.samhsa.gov/data/NSDUH/2k12MH_FindingsandDetTables/MHDT/NSDUH-MHDetTabsSect2peTabs2012.htm#Tab2.6B

State Secretariat of Public Health and Social Assistance, Pan American Health Organization, WHO Department of Mental Health and Substance Abuse. (2008). *WHO-AIMS report on mental health systems in the Dominican Republic*. PAHO/WHO/SESPAS. Retrieved from http://www.who.int/mental_health/dominican_republic_who_aims_eng.pdf

The Lancet. (2007, May). *Mental illness, a neglected disease*. Retrieved from PAHO: http://www1.paho.org/english/dd/pin/ptoday06_jul08.htm

World Health Organization. (2011a). Dominican Republic. *In Mental health atlas-2011-country profiles*. Retrieved from World Health Organization: http://www.who.int/mental_health/evidence/atlas/profiles/dom_mh_profile.pdf?ua=1

World Health Organization. (2011b). United States of America. In *Mental health atlas-2011-country profiles*. Retrieved from World Health Organization: http://www.who.int/mental_health/evidence/atlas/profiles/usa_mh_profile.pdf?ua=1

World Health Organization. (2014). *Gender and women's mental health*. Retrieved from World Health Organization: http://www.who.int/mental_health/prevention/genderwomen/en/