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no man should be an island, neither should any woman

LOOKING AT MENTAL HEALTH IMPROVEMENT, SOCIAL NETWORKS AND GENDER

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Executive Summary

The Scottish Government's National Programme for Improving Mental Health and Well-being is increasingly interested in a population-based approach to promoting mental health in Scotland. Additionally, tackling inequalities in mental health is one priority of its future agenda. This report attempts to further unpack the notion of a true population-based approach to mental health and inequalities. It explores the different experiences of mental health for women and men through an examination of their social networks as a specific protective factor. Taking gender into account when considering the role of social networks in mental health and well-being may seem obvious in practice, but, as found in consultation with practitioners, it is often both complex and overlooked. Drawing upon preliminary focus group research with the general public and conversations with practitioners across Scotland, this report intends to highlight gender issues that influence social networks, which are found to be protective for mental health. It also hopes to raise awareness and promote further discussion around mental health improvement and gender in practice.

Importance of social networks for mental health:

- Providing a buffer to stress and anxiety
- Contributing towards a sense of purpose
- Contributing towards stability in one's life
- Improved self-esteem, confidence and interpersonal skills
- Improved social support and trust.

Key findings:

- Stereotypical gender roles influence men and women's ability to form and maintain social networks
- Women's networks are typically composed of several close people to confide in, with a high number of family, and are often large in size
- Men's networks tend to be large in size with a higher number of co-workers and may be task-oriented with a focus on hierarchal standing
- In general, support from friends during hard times was preferred over support from family
- Some difficulties were experienced when sustaining or developing new friendships through transitional periods.

Considerations for practice:

- Motivating people to attend networks/groups or getting people 'through the door'
- Creating opportunities for people to make and sustain friendships
- Developing individual skills & characteristics may help promote social networks such as interpersonal skills, confidence, trust, interdependence
- Encouraging social networks and individual skills is a part of a process in maintaining and widening one's social networks
- Supporting men and women in building networks
- Supporting women in harmonising family, work and social life.

Table of contents

Executive Summary 4
Introduction 6
Gender 7
  Mental health and gender 8
    Trends in risk and protective factors by gender 8
    Definition of mental health by gender 9
Social networks 10
  Definition 10
  The impacts of social networks on health and determinants of health 11
    Within mental health promotion theory 11
    Adverse and complex impacts 12
    Positive impacts 12
    Specific aspects of social networks that promote mental health 13
The current research 14
  Methods 14
  Findings 15
    Gender and local practice 15
    Defining health 16
    Networks and relationships for women and men 17
    Confidants and cross-gender perspectives 19
    Friendship and life course 19
    Friends compared with family 21
    Difficulties for new comers 22
    Challenges of social networks 23
    Benefits of social networks 24
Limitations and future research 25
Considerations for practice 26
  The process of social networks 27
  Gender and social networks 27
  Isolation and social networks 27
  Cultural and structural shift 28
Conclusion 28
References 30

Introduction

While the practice of mental health promotion has existed for decades if not longer, improving and promoting the mental health of individuals and populations has been gaining increasing interest and support across the globe recently (*cf.* WHO Mental Health Declaration, 2005; Mental Health on the European Agenda, 1997; Towards a Healthier Scotland, 1998). Promoting mental health independently of other aspects of health may have its merits. However, its true strength, and more true to the holistic nature of health promotion, is promoting mental health in conjunction with lifestyle and physical health (O'Hara & MacDonald, 1998). In 2005, the World Health Organization (WHO) developed a report on promoting mental health emphasising the connection between a person's overall health and their mental health (WHO, 2005). The WHO and the European Union also recognise the importance of both promoting mental health and preventing mental-ill health (*e.g.* WHO, 2005; Lehtinen *et al.,* 1997; Lehtinen, 2004; ESCAP, 2007; MHE 2008). Health promotion, in general, is often linked with both promotion and prevention, as these actions are seen to compliment one another (*cf.* Downie *et al.,* 1990). When considering the promotion of mental health, three levels can be taken into account: individual, social and societal/structural (Lehtinen *et al.,* 1997; Barry & Jenkins, 2007). Mental health promotion works across these levels to foster positive mental health in individuals and communities and to reduce barriers to mental health (Department of Health, 2001).

Stemming from the increasing attention on mental health promotion, the concept of 'mental health improvement' has been created to envelop these notions of mental health promotion including the beliefs, attitudes and behaviours of individuals, but also broader socio-economic and environmental determinants (Friedli *et al.,* 2007). Mental health improvement is used to describe any action to increase mental health which may include action "aimed at promoting mental health, preventing mental health problems and improving the quality of life of people experiencing mental health problems" (Friedli *et al.,* 2007:5).

Nationally, Scotland has upheld this relatively new concept and worked to put mental health improvement into practice and policy. Mental health has been a priority in Scotland for over a decade and the Scottish Government's commitment to mental health improvement and promotion continues (*c.f.* Scottish Executive, 1998, 2000; National Programme, 2003; Towards a Mentally Flourishing Scotland discussion paper, 2007).

Upholding Scotland's commitment to mental health, in 2005, a report called *Equal Minds* drew attention to the significance of inequalities in mental health (SDC, 2005), highlighting that inequalities are not random but are typically determined by social divisions (Pilgrim, 2003 cited in SDC, 2005). These divisions include socio-economic status, social identity and the experience of mental health problems (SDC, 2005). Of particular interest here is the impact of social identity. Gender is one factor amongst others, such as age, sexual

orientation, and religion, which create one's social identity. However, these divisions do not exist in isolation. For example, research in Britain shows women are more likely to be poor due to lower paying jobs and childcare responsibilities and thus experience increased social isolation (Barnes *et al.,* 2002 cited in Stagg *et al.,* 2007), which has been shown to contribute to poor mental health. Here, these social divisions intersect: gender influences socio-economic status and ultimately influences mental health.

Although *Equal Minds* (SDC, 2005) drew attention to the gender differences of mental health, this report hopes to contribute to improved awareness and understanding of gender, particularly from the positive or promotion aspect of mental health improvement. The initial basis was to explore whether positive mental health is experienced differently by men and women. In order to create a more specific focus, conversations were held with practitioners across Scotland to determine their perspectives on gender and mental health improvement (10 total). Such conversations and a review of the literature helped focus this research on a specific protective factor -- social networks. The presence of social networks contributes to the prevention of mental health problems and the promotion of positive mental health for men and women. Gender-differentiated focus groups were then carried out to explore gender, relationships and health. The aim of the research was to gain an understanding of how social networks differ for men and women, which may then help to support social networks and ultimately promote mental health. The data from this research was presented to practitioners at a workshop to discuss the findings and consider implications for practice. Both accounts with practitioners (the initial conversations and the workshop discussions), and the focus group data will be considered in this report. However, before looking at these sources, some background on gender and social networks will be reviewed since these are main concepts of the research and can be fairly complex. Overall, this report intends to highlight gender issues that influence social networks, which are found to be protective for mental health. Such considerations are hoped to stimulate interest and awareness in practice and possibly ignite further discussions and developments.

Gender

Sex, or the biological characteristics that define men and women, can determine the propensity for health risks and treatment requirements. However, gender influences the control men and women have over the determinants of their health (WHO 2000), including treatment seeking patterns, general treatment and social status in society, economic status and access to resources (WHO 2000; Greaves *et al.;* 2000). The WHO defines gender as "the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women" (WHO, 2008). This is "fundamental to our sense of who we are, the roles we adopt, the way in which we experience and perceive others and in which they perceive us" (Department of Health, 2003:9). Gender itself is a complex determinant that can affect both the material and symbolic status men and women hold within society (WHO, 2000). Given its interaction with other social determinants,

gender can have profound effects on health. For instance, it is known that mental health problems affect more women than men (Palmer *et al.,* 2003 cited in SDC, 2005), but why? Looking at such an issue with a gender lens helps explore why such a trend may occur. One explanation may include the tendency for women to seek health care more often then men (Winkler *et al.,* 2005; Bennett *et al., 2006)*. The statistic that declares men experience fewer mental health problems may be due to the fact that men do not acknowledge such problems or are simply not seeking help (Winkler *et al.,* 2005; Bennett *et al.,* 2006) and are thus not counted. Therefore, the finding may be an artefact. Considering gender may modify or deepen one's understanding of health, health trends and determinants of health.

Mental health and gender

Trends in risk and protective factors by gender

Mental health promotion works to strengthen factors which protect mental health and reduce factors that increase the risk of mental health problems (Barry & Jenkins, 2007). Often, bolstering a protective factor has the inverse effect of reducing the correlating risk factor[1]. In general, activities that promote mental health focus on enhancing skills, knowledge and support at all levels of mental health promotion, individual, social and societal/structural (Lehtinen *et al.,* 1997).

Gender has a large impact on exposure to and experience of risk and protective factors (Department of Health, 2001). In terms of the three levels of mental health promotion, gender may influence risk and protective factors mostly between the social and societal levels, but may also culminate at the individual, psycho-social level. Examples of the differential experience of risk and protective factors for men and women include:

Risks factors:

- Unemployment
  Experienced by more men (SDC, 2005) and has a greater negative affect on them, particularly those who are married since marriage contributes to defining their family responsibilities (Artazcoz *et al.,* 2004)
- Poverty
  Affects men and women differently, with women being more sensitive to disadvantage in childhood and men more sensitive to lack of socio-economic success (Tiffin *et al.,* 2005).
  Overall, poverty is experienced by more women (Patel, 2005).
- Divorce
  Divorced men are at a higher risk of suicide (Kposowa, 2003)
- Stress
  The dual role of women, at work and at home, increases exposure to stress (Fuhrer *et al.,* 1999; Simon 1995)

[1] Tables of risk and protective factors can be found elsewhere, *e.g.* see Barry & Jenkins, 2007.

Protective factors:

- Marriage
  Acts as a buffer for unemployed women (Artazcoz *et al.,* 2004)
  Marriage is protective since it provides economic and emotional benefits of living with someone (Artazcoz *et al.,* 2004)
- Balancing work and life
  Combining work and family is less stressful and more protective for men (Simon, 1995)
- Social networks and social support
  Protective for both men and women (Hintikka *et al.,* 2000; Fuhrer *et al.,* 1999).

Exploring these factors from a gender perspective can provide some understanding of how this translates into the mental health of men and women. Using risk factors as examples may illustrate this more easily. First, rates of suicide in Scotland are four times higher in men than in women (Meltzer *et al.,* 2006 cited in Department of Health, 2001). If gender issues are considered a number of explanations surface. One possible explanation is that men use more aggressive methods of suicide and act out depression differently than women (Winkler *et al., 2005*). This may perhaps be due to their more aggressive, risk-taking role in society (Naidoo & Wills, 2005). Also, men are less likely to seek help and may thus be later in stages of mental illness when seeking care (Winkler *et al.,* 2005; Bennett *et al.,* 2006).

Second, women experience higher rates of depression and anxiety than men (Patel, 2005; Pinccinelli and Wilkinson, 2000 cited in Department of Health, 2001; Bennett *et al.,* 2006). In Scotland, female patients were twice as likely as male patients to be suffering from these mental health problems (Breithbach & Wassof, 2007). Health care workers have been found to view women's problems as mental and men's problems as physical (Browne, 2006) and thus, women may be more quickly diagnosed for mental health problems. This highlights how gender can influence the ways in which others perceive women. An additional explanation for higher rates of depression and anxiety include upholding professional, family and mothering roles (Fuhrer *et al.,* 1999; Simon, 1995; Lucht *et al.,* 2001) Gender roles and their consequences will also be considered for social networks in future sections.

Definition of mental health by gender

Men and women have different propensities for both the risk and protective factors of mental health. However, how do men and women see the outcomes of these factors? Determining if men and women define mental health and mental health problems differently was difficult to find in the literature. One Swedish study used qualitative methods to determine how elderly women define (positive) mental health. The results of this study showed that, for them, positive mental health was to "experience…trust and confidence in the future…and involvement in one's relationships to oneself and to others" (Hedelin & Strandmark, 2001). In Scotland, statistical studies have concluded that men report marginally higher levels of psychological

well-being than women (68% compared to 61% in 2003) (Breithbach & Wassof, 2007), but there is no clarification on the definition of well-being being used by these men and women.

Uncovering a notion of how men and women see mental health, positive and ill-health, may help shed light on men and women's experiences with mental health.
Gender influences values, assumptions and one's role within society and these same values create an understanding of mental health in a given society (Caplan & Holland, 1990; Tudor, 1996 cited in Barry & Jenkins, 2007). Just as mental health definitions should be sensitive to culture and context, so too should there be gender sensitivity when considering how men and women may define mental health.

Social networks

Definition

The Australian government defines social networks as:

> The personal or professional set of relationships between individuals. Social networks represent both a collection of ties between people and the strength of those ties. Often used as a measure of social 'connectedness', recognising social networks assists in determining how information moves throughout groups, and how trust can be established and fostered
>
> (Scrutiny of Acts and Regulations Committee, 2005).

More plainly, social networks are made up by the people one interacts with on a regular basis. Social networks can vary in terms of the number of 'members', general composition, the frequency of meetings, geographical proximity, and structure (Ajrouch *et al.,* 2005) which have implications for how a social network forms and functions and will be discussed more in discussion of the research. Social networks function by encouraging and contributing to social processes, such as social support, social cohesion, trust and social integration (Almedom, 2005; Whitley & McKenzie 2005; Hinson Langford *et al.,* 1997).[2]

[2] The concept of social capital has been created to describe such features of social relationships (Barry & Jenkins, 2007). Social capital includes social networks but also refers to the "shared norms and understanding that facilitate cooperation within the group" (Scrutiny of Acts and Regulations Committee, 2005). A variety of debates exist around the concept of social capital, thus for simplicity, the phrase social networks will be used in this report but may include notions of social capital.

The impacts of social networks on health and determinants of health

Within mental health promotion theory

Theoretically, a number of models of health promotion and mental health promotion reinforce social networks as a protective factor of mental health. At the basis of health promotion is the WHO's Ottawa Charter for Health Promotion which strives to empower individuals to improve their physical, mental and social well-being (1986). Promoting positive social networks contributes to core health promotion actions set out by the Charter including creating supportive environments, strengthening community action, and developing personal skills. Such actions of the Ottawa Charter continue to drive health promotion efforts today.

From a mental health promotion perspective, MacDonald and O'Hara's 'Ten Elements of Mental Health' is attentive to both the factors that promote and demote mental health.

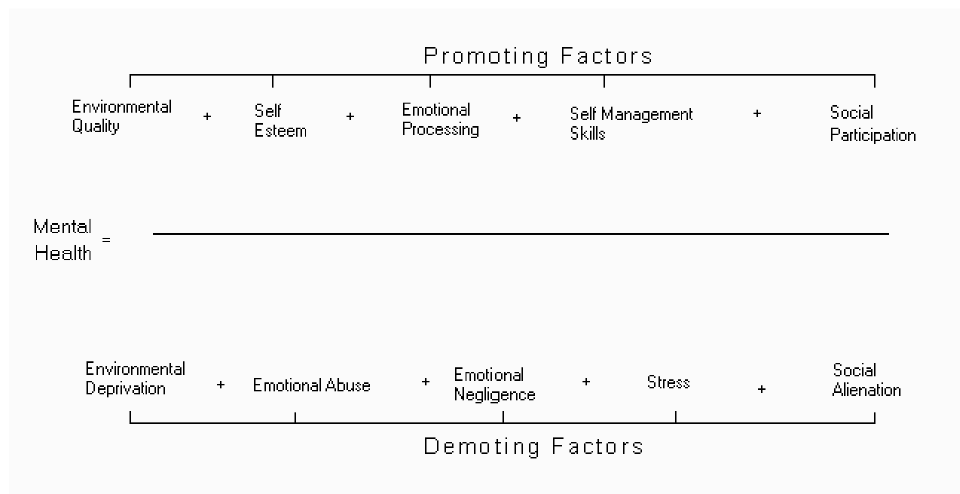

Figure 1: Ten Elements of Mental Health

Mental health can be promoted by encouraging the elements on the top part of the 'equation' and by discouraging the elements on the bottom part of the equation. Considering the levels at which the promoting and demoting factors operate, which MacDonald and O'Hara suggest as individual, local, organisational and national, and the specific factors themselves can aid in identifying and planning mental health improvement programmes (MacDonald and O'Hara, 1998). Social networks are not limited to just one factor or level of this model as relationships and networks interconnect and interact with several. MacDonald and O'Hara stress the fact that the elements should not be looked at in isolation, but in their interactions with one another (1998). Given that these elements exist in a social sphere, their interaction with social relationships is natural. The promoting elements of this model reinforce positive social networks as promoting and protecting mental health through

the environmental quality element for encouraging social inclusion, the emotional processing element that contributes to how we believe others see us, and the social participation element which involves others adding to the "the social richness of our lives" (MacDonald and O'Hara, 1998:18).

Adverse and complex impacts

Certain aspects or characteristics of social networks may demote mental health. Social networks have the potential to have a wide influence (*e.g.* through increased community participation), but "individuals who are less willing or able to engage with others do not seem to profit directly from the available social networks" (Poortinga, 2006: 257). Occasionally, the same strong ties and relationships that promote health and mental health can also exclude non-members from that network (Portes and Landolt, 1997, Colletta & Cullen 2000 cited in Cullen & Whiteford, 2001). For example, characteristics that members of groups or groups themselves share, such as gender, race, and class, may contribute to the exclusion of others. Additionally, networks may exist that promote or permit 'negative' behaviour, such as smoking or drinking. Although negative behaviour may be encouraged in such networks, members may find these networks supportive and beneficial. The depth of this topic is not sufficiently addressed here, but is recognised as an important area to explore further.

In relation to socio-economic status and social networks, some literature sources argue that strong social networks may diminish the adverse effects of living in a disadvantaged community and may protect people's health in the presence of inequalities (Stafford & Marmot, 2003 and Kawachi & Kennedy, 1997 cited in Griffiths *et al.,* 2007). It may be the subjective type or amount of support available that can predict well-being over socio-economic indicators (Hicks Patrick *et al.,* 2001; Pugliesi & Shook, 1998). However, social networks alone are not sufficient for overriding the effects of deprivation (Friedli *et al.,* 2007). Thus, when comparing two equally deprived communities, the community with stronger social networks may have higher levels of mental health. But if this same deprived community with strong social networks is compared with a more affluent community also with strong social networks, the mental health outcomes for the affluent community are likely to be greater.

Positive impacts

Extensive literature exists on the beneficial effects that positive social networks have on all aspects of health. Networks have been found to be a protective factor for positive health and social outcomes (Moodie & Jenkins, 2005 cited in Barry & Jenkins, 2007). "There is good evidence that more socially isolated individuals have poorer health and more socially cohesive societies are healthier with lower mortality" (Barry and Jenkins, 2007:86). In terms of physical health, social networks have been determined to decrease the risk of mortality, accidents, cardiovascular disease and infectious disease (Kawachi *et al.,* 1996; Berkman & Syme 1979 cited in Whitley & McKenzie,

2005; Cohen *et al.,* 2000). For example, a man who experiences social isolation significantly decreases his chance of survival after heart disease, cancer and stroke (Courtenay, 2000 cited in Courtenay, 2003). These networks have also been found to influence behavioural health, such as smoking, exercise and sexual activity – those with low levels of social participation were more likely to be smokers and less likely to exercise (Cohen et al., 1997 cited in Cohen *et al.,* 2000; Cullen & Whiteford, 2001; Berkman *et al.,* 2000 cited in Veenstra *et al.,* 2005).

The benefits of social networks may be seen most widely in terms of mental health. Strong social networks contribute to a decreased likeliness of depression (Brown & Harris, 1978 cited in Whitley & McKenzie, 2005), protect against suicide and dementia (Gerlad & Weissman, 1989, Fratiglioni *et al.,* 2000 cited in Friedli *et al.,* 2007) and contribute to overall mental health maintenance (Poortinga, 2006; Caplan, 1974 cited in Whitley & McKenzie, 2005). The relationships between social networks and mental health are interactive and mutually reinforcing: improving social networks leads to improved mental health and improved mental health leads to more positive, stronger relationships (Sartorious, 2003 cited in Cattan & Tilford, 2006).

Relationships between individuals protect our mental health and also help us when we are mentally unwell. Small social networks have been associated with the development of mental illness (Brugha *et al.,* 2005). Both the onset of mental illness and a poor recovery process from this illness have been associated with a lack of social support (Pevalin & Goldberg 2003 cited in Friedli *et al.,* 2007). Social network therapy has been used with mental health service users to bring their community together to provide support for the person and their family (Gillies & Wasylenki, 1993). Research has shown that social support helps mental health service users on their road to recovery (Faulkner & Layzell, 2000, Faulkner, 1997, and Faulkner, 2002 cited in Friedli *et al.,* 2007).

Specific aspects of social networks that promote mental health

The basic strengths of social networks is in their ability to encourage social support and trust, improve information exchange, facilitate interpersonal bonding and, possibly, improve social or civic participation (Poortinga, 2006; Bolger & Eckenrode 1991 cited in Hintikka *et al.,* 2000; Berkman *et al.,* 2000 cited in Veenstra *et al.,* 2005; Cullen & Whiteford, 2001). Such mechanisms of relationships have individual implications including improved self-esteem, a sense purpose through fulfilment of social identities, and the creation of a protective buffer to stress and anxiety (Poortinga, 2006; Bolger & Eckenrode, 1991 cited in Hintikka *et al.,* 2000; Thoits, 1983 cited in Cohen *et al.,* 2000). On a more social level, within networks or communities, these relationships provide a sense of cohesion and collaboration (Cattan & Tilford, 2006). Interestingly, it is "the level of perceived support, rather than actual support that is the key factor in influencing mental health" (Dunkel-Schetter & Bennett, 1990 and Wethington & Kessler, 1986 cited in Friedli *et al.,* 2007:24). Although there are negative and complex aspects to social

network's impact on health and its determinants, overall, social networks are seen as a positive factor in supporting good mental health.

The current research

This research is guided by the premise that promoting social networks can promote positive mental health, as seen from the above discussion. It explores whether social networks differ for men and women and if so, attempts to locate some of these differences. Awareness of how social networks differ for men and women may help promote social networks, and by promoting social networks we can promote positive mental health.

Methods

Four semi-structured focus groups were used to explore health and relationships with the participants. Gender-differentiated groups were chosen to help locate specific differences between men and women. Due to the tight timeline of the research, existing communities groups or formal networks were used and were located through local community practitioners. These men and women groups created opportunities for participants to be involved in various activities or to meet others in their community. These groups were made up of a range of people from the community but did not specifically focus their activities on mental health or target mental health service users. Two of these communities groups, Glasgow and Dundee, are in the top twenty most deprived areas of Scotland, and one, Aberdeen, has an unemployment rate that is double the national average (6.3% compared to national average 3.5%) (NHS Grampian, 2003; BBC, 2003); however, these communities were not specifically sought out.

	Location	**Number of participants**
Men's group	Dundee	7
Men's group	Glasgow	14
Women's group	Aberdeen	14
Women's group	Inverness	13
	Total participants	**48**

Table 1: Details of focus groups

The age of women's groups ranged from twenties to mid-sixties, with the majority in their thirties and forties. The men's groups were in their thirties to mid-sixties, with the majority in their late thirties or early sixties. Discussions took place during normal group meeting times. A 'warm up' was used in order to take note of participants' names and encourage conversation. A consent form was verbally explained, followed by participants' review and signature. The sessions were recorded and scribed. 'Stimulus' statements around health and relationships were used to encourage conversation amongst groups, including themes such as: trust, family, friends, stress, health and well-being, confidants, involvement in community, and perspectives about the opposite sex. Attendance and interest in the discussions appeared to be high in all groups. Mental health or gender was

not mentioned specifically to the groups; the purpose was described as simply exploring health and relationships. The broader subjects provided space for the groups to explore the notions of health, mental health, relationships and gender themselves. This allowed for discussion and themes to naturally occur around such topics and ideas were not 'planted'. A comparison between these groups contributes to understanding the differences and similarities between social networks for men and women, discussed below.

The below findings were presented through a workshop to practitioners who represented a number of different vulnerable population groups across Scotland (approximately 30). This report encompasses the interactions from focus groups and conversations with practitioners, as well as existing literature, in a triangulated approach comparing all three sets of data.

Findings

Gender and local practice

In Scotland, there is a current need to initiate thinking about mental health and gender, as shown from conversations with practitioners. Gender was either simplified to mean women only or was given no recognition. Several practitioners did not include men in their thinking on gender. Explaining issues in terms of gender was a way of looking at how women are affected by certain aspects. This perspective is fairly understandable given that, historically, women have dealt with greater disadvantage than men in many arenas of life; however, men also experience disadvantage and gender issues that influence their mental health. Men and women gender issues do not occur in a vacuum and thus have an influential relationship on one another.

Other practitioners described the local services for men and women without realising the gender issues behind their programmes. Services should recognise the individual, however, differential experiences may exist across gender. "A recognition of gendered social factors reveals that men and women sometimes have different kinds of experiences and when they do have the same experience they may be impacted differentially" (Morrow, 2002:18). Assessing the needs of groups and communities with a gender perspective may bring about improved understanding and effectiveness.

Practitioners who had an awareness of gender issues discussed whether gender sensitive or gender specific programmes were most appropriate. First, practitioners found that some people requested gender specific programmes. Here, it seemed that women often identified the need, such as a jogging group or a cooking group, and the men would then mimic or express their need for a similar type of programme. However, the men and women asked for separate spaces for their networks. Interesting gender issues exist here including aspects of men and women's identity, their roles and how they prefer to socialize, some of which will be discussed in other sections. Second, some practitioners felt gender sensitive services were more feasible financially and logistically. Practitioners argued that thinking about

how gender may impact services, or being sensitive to it, also helps people function in a real life approach of men and women interacting together. The beliefs of these practitioners accentuate the need for more awareness and dialogue surrounding gender issues and practice.

Defining health

Health was the first topic the focus groups were asked to discuss. Participants were asked to use words to describe what health meant to them. Most participants described health with words such as healthy eating and exercise. Physical health was described as "my body in nae bad order". Mental health was also included mostly as a secondary thought and was expressed as happiness, being able to cope, and the strong effect of depression.

Both men's groups thought it was difficult for men to talk about their depression as many are embarrassed about it and want to hide it. Similar findings have been proposed in other studies which argue that men withdraw from society and try to talk themselves out of being depressed (Courtenay, 2000 cited in Courtenay, 2003). One men's group also discussed mental health in terms of the importance of anti-stigma towards those who experience mental illness.

There were a number of interesting descriptions in these discussions. Health was seen as the ability to access information; being given the opportunity to be informed was seen as important step in being health. This women's group expanded on this to also include being proactive about your health. The men's group, who were of retirement age, were skeptical of defining health, asking "Is there a completely healthy person?'" These men believed that health was a notion that can be dissolved by 'something going wrong' that causes you to seek health care.

To gain insight into some of the gender stereotypes that exist within these groups, they were asked what words the opposite sex would use to describe health. Men were asked about how wives, girlfriends, female friends, *etc.* would describe health and vice versa. Both descriptions of the other sex imply some interesting gender stereotypes. The women's groups said the men in their life were brought up to be hard and not to show their feelings. Society often portrays men as being tough and aggressive (Naidoo & Wills 2005) and one author, Courtenay, explains that men and boys may experience more social pressure to adopt societal beliefs about the male gender (Courtenay, 2000 and McCreary, 1994 cited in Courtenay, 2003). Overall, there was a sense that men were changing and becoming more sensitive to emotions and more knowledgeable about health. This was particularly evident with eating in which the women attributed to their own and the television's influence. Some of this is supported by the literature as it has been found that a woman can have a positive effect on men's health behaviour (Steinberg, 1998)

Men thought the women in their lives would describe health as sexual health, comfort, and the wife being happy if the husband is happy. Such descriptions resonate with the stereotypical female filling a passive role (Naidoo & Wills, 2005). One man in retirement said that originally he would've said women are quicker to go to the doctor, but since he had come to have, what he called, 'bad health', he is now quick to go to the doctor. Seeking health care may typically be seen as a woman's approach, however, typical gender roles may transform over time.

Awareness and understanding of a client group's or a community's conception of health is important in practice. Similar to identifying the needs of a community, locating their perceptions of health contributes to a more holistic and effective approach to services.

Networks and relationships for women and men

In general, the gender roles of men and women effect how they form and sustain social networks and the groups who participated in the research tended to uphold common gender roles overall.

Women

The women in my research highlighted that the stress in relationships typically stemmed in their role as care takers. This stress was described by the burden of having to organise family life and commitments. A woman explained, "you give some to your family, and then try to give some to your friends. Family is often why I can't be closer to my friends". Both time, or lack thereof, and one's own personal problems were thought to degrade the response to a friend's problems. Here, women tended to demonstrate a sense of self protection over their own well-being. Another woman, in a discussion about well-being, illustrated this by equating well-being with the ability (time and money) to be able to send her children to day care. She expressed the importance of her social networks on her well-being, but in order to participant in these networks there needed to be an option for being relieved from her caretaking role. Other women articulated the stress of a family as having to care for their aging parents. These women found they had to put their own life on hold in order to sort out their parents' issues. Dividing their time in such a way contributed to their overall stress.

These are examples from the research data of how women struggle to form, access and maintain social networks, largely because of their gender role, which have been discussed in the literature in some interesting ways. First, studies show that women do not always respond to stress through 'fight or flight'. Instead of standing up to a stressful circumstance or fleeing from it, women have been found to 'tend and befriend'. In this response, women nurture themselves and their young (tending), and form alliances or maintain social networks (befriending) when dealing with stressful situations (Taylor *et al.*, 2000). Women seek to create networks and support that buffer stress which likely contributes to better mental health.

Second, men and women traditionally have different roles in the workplace and the family (Simon, 1995). Women often have multiple roles such as professional work, caring for members of the family and housework. Women are more often tied by family and social obligation and are less free to walk away than men (Brugha *et al.,* 2005). Women may be disproportionately responsible for domestic work and thus multiple, demanding roles may create what is termed the 'triple burden'. The first role is the woman being in charge of house work or taking care of the family, the second role is professional work and then as a result of these two stressors, women may feel isolated and have a lack of social networks (Gupta *et al.,* 2004). Women who experience social isolation as a result of the triple burden may be at an increase physical and mental health risk.

Women's network composition
These roles influence the make up of a women's network. A typical woman's network has:
- Several close people to confide in
- A high number of family members
- A large total number of members.

(Moore 1990, Fuhrer *et al., 1999*).

Men
In this research, men described stressful relationships as those in conjunction with providing. A discussion with one men's group started with nostalgia for the old days as a time when children were perceived to have been more respectful and thankful. Men described the pressure to get children the newest, coolest products as stressful. Here, there was a sense that providing has evolved to be more than simply putting food on the table. The literature finds that a woman's multiple roles may be seen as conflicting but for men the role of work and parenting is synonymous. Men see combining work and family as natural. (Courtenay, 2003). Dissimilarly, my research found that combing work and family could be stressful for men as well as for women. For example, a retired man described time with his own children as demanding because of limited time due to work. However, his experience with his grandchildren was enjoyable because of the additional time retirement allowed. In accordance with the literature, men's networks often switch from being a high number of co-workers to a high number of family members with older age (Arjouch et al., 2001).

Men's network composition
The literature articulates several general traits of a man's social network:
- Large social networks
- High number of co-workers (Fuhrer *et* al., *1999*)
- Purpose orientated, such as outings and tasks (This research, Zunzunegui *et al.,* 2003)
- Emphasise hierarchy over intimate bonding (Zunzunegui *et al.,* 2003).

Overall, men are more likely to use avoidant coping strategies and are less likely to employ vigilant coping strategies by acknowledging that they need help (Courtenay, 2003). For both men and women, larger networks, or a higher number of friends, are predictors for better mental health (Hintikka *et al.,* 2000), but more so for men. Simply stated, a small network for men can be seen as riskier than a small network for women.

Knowledge of the typical composition of women and men's social networks can help to understand women and men socially and also provide insight into the support they may need. It can also help determine what types of formal networks may be most successful in practice.

Confidants and cross-gender perspectives

The focus groups were asked if their relationships with men and women were similar. The first reaction from the women's groups was overwhelmingly in disagreement that their relationships with men and women were the same, but overall the men believed the relationships were the same. In general, both the men's and women's groups thought women were easier to talk to and more trustworthy. A study on British civil servants found that men largely confide in one close person, who is often their spouse and women often have one close confidant who is someone other than their spouse (Fuhrer *et al.* 1999; also see Courtenay, 2000 cited in Courtenay, 2003). Both of these roles may generally be taken on by women. In the research for this report, women were seen as better people to talk to about health issues, whereas joking and laughing were typical interactions with men. There is value in both of these roles for mental health.

In discussion with one practitioner, it was felt that there was minimal success in engaging men in the programme and that involving women was much simpler. For this practitioner's programme, the next step may be to focus on women to reach out to and influence men. This research and the literature potentially support this type of approach. The spouse may be an ideal person to include since men report more positive support from their spouse than their male friends. However, negative social interactions with a spouse create more risk for mental health than negative interactions with friends, for both men and women (Bertera, 2005). Such an approach has potential and scope, but there is a need for exploring this further.

Friendship and life course

The idea of friendship changing came up frequently in all focus groups. Friendships were seen as running a course by explaining that 'friendships come and go'. A number of themes surfaced around life course and friendship course including relocation and geography, growing older, bereavement, and getting married.

Geography

First, the geography of friendships came up. More mobile people found it difficult to maintain old friendships and build new ones simultaneously. In general friend circles were thought to dwindle upon relocation. On the other hand, people who were born and raised in the same place seemed to have strong links with a small group of good friends, explaining "the friends you have when you're young are the friends you keep". It may be fairly apparent that proximity helps with maintenance and encouragement of social networks (Arjouch *et al.,* 2001). However, based on my research, these affects of mobility seemed more prominent for women than for men. The facilitation of both informal and formal networks is likely to be important for people new in the area.

Aging

Second, nearly all participants recognised that growing older caused a number of different approaches for making friends. A middle-aged woman explained that "I no longer meet their friends at the pubs, you have children and everyone else does so it's different". Most women used links made from their children as an avenue to meet new people and make friendships. The creation of networks across the age-span is important to consider since methods for meeting people may change. Also, the receptiveness to new friends may also change with age.

Friendships were seen as beneficial for the men in the retirement group, but new friendships were viewed with slight hesitation of trusting people and allowing people to be close. A retired man explained, "As you get older you're more hesitant to make friends". Congruently, the literature explains that quality of older people's networks may increase due to the concentration on relationships they find most helpful (Arjouch *et al.,* 2001). The literature explains that non-kin ties rise during young adult years and then fall after that point, while kin ties increase with age (Moore, 1990). In further explanation, it is argued that the networks of older people transform because their roles change, for instance, they may no longer be active parents or employees. Equally, the composition of their network changes due to the death of friends and family. (Grossman *et al.,* 2000).

Bereavement

As networks change with age, men typically rely more on their spouse, particularly if their male friends may have passed on (Grossman *et al.,* 2000; Pugliesi & Shook, 1998). This reliance on the spouse can create hardships during bereavement. The loss of a spouse was briefly mentioned in one men's group. The grief and loss created a lack of confidence which effected interactions with current friends and attempts at creating new friends. Both men and women can likely identify with this honest account of the effects of losing a loved. However, men may need additional support in dealing with bereavement. Support may be particularly important with the loss of a spouse, as they may be their sole confidant. Typically, men are less emotional or less able to show their emotions which may lead to difficulties

when dealing with grief. Women have been found to cope with grief more easily due to the multiple close confidants in their networks and their tendency to be better at coping with emotions (Buchebner-Ferstl, 2003).

Committed relationships and marriage

The third theme uncovered was the effect of committed relationships or marriage on relationships between males and females. One women's group identified two basic opposing opinions on this topic. The first opinion identified risk and poor understanding. It was believed that once male friends had serious girlfriends or wives, developing or maintaining close friendships with women was more difficult because the partner in the man's life saw female friends as threats. Also, female partners were believed to have ill understanding of old friendships. The other opinion recognised opportunity and relief. Relationships were seen to change between men and women in a good way with the marriage or increased commitment. The potential for the relationship to be more than friendship or to be sexual was either diminished or alleviated. For some women, this 'relief' provided an opportunity to develop a deeper relationship with men. Partners may change the course of friendships. In both formal and informal networks this may bring about emotions about specific relationships or about simply being in a mixed gender group. Also, membership to a certain network or group may or may not affect those outside of the group, such as partners.

Friends compared with family

Participants in all groups were prompted to discuss whether they preferred talking with friends or family during times of personal crisis. While most responses acknowledged circumstances, the majority felt that it was easier to talk with friends during hard times. Simply being with friends, and not necessarily discussing issues with them, was seen as being helpful since these relationships are often more relaxed. Friends were sought to help with health, personal and relationship issues; whereas, family was identified as possibly being consulted with financial or work issues. Family was seen to be critical and respond more negatively to the person's situation. "If I wanted to know the worst aspect of it, I'd tell my mother, but if I wanted something positive, I'd go to my friends", one woman explained. Some participants sometimes saw such critiques as being a source of family pressure. Additionally, one man believed that his emotional tie to his family would cause them to worry about him in times of crisis and thus was hesitant to discuss such issues with them.

There is extensive, corroborative literature on friend support preferred over family support.

- Family relationships are important but are generally obligatory
- Friendships are optional and may therefore create feelings of autonomy
- Friendship ties tend to be more egalitarian and have lower expectations for support than family
- Friendships can provide intimacy, companionship and integration into a community and broader society.

(Hicks Patrick *et al.,* 2001).

Social negativity, such as stress or criticism, with spouses or relatives was more strongly associated with mental health problems than social negativity from friends (Bertera, 2005). In other words, if your family is hard on you, it may be worse for your mental health than if your friends are hard on you. In another study on older adults and mental health, the absence of family within the context of friends was less detrimental to mental health than the absence of friends in the context of family support. (Fiori *et al.,* 2006). Plainly stated, having more friends in your network may be better for mental health than having more family members (*Fiori et al.,* 2006; Bertera, 2005). A variety of the available studies seem to demote the importance of family but an emphasis is made for the diversity of networks: a network made up of both friends and family.

The higher reliance on friends rather than family poses some interesting implications for practice. Family is seen as important, particularly in given circumstances, but in general, men and women in these focus groups, and in most of the literature, view friends as being more supportive and thus contributing to mental health. Practitioners can help create opportunities to develop and maintain friendships. Within these already existing community groups which participated in the research, both the men and women felt that good friendships had been formed within the group. Practitioners may be able to contribute to the process of establishing friendships and support which can contribute to positive mental health.

Difficulties for new comers

Rural

The research in the rural Highlands uncovered an interesting issue about the rural way of life, and in particular for those new to the area. Women new to the area felt it was hard to make new friends and establish relationships in the Highlands specifically. Integration into other rural areas in Scotland, such as areas in the Borders, was believed to be less difficult. There was a perception that local embedded relationships with family and friends had little room for new friendships. Such a notion was emphasised by a local woman who believed rural people try to be friendly, but their friendships are already established. And another local woman reiterated this further by stating, "new friends don't have the same depth". One story was told about a woman who had lived in the Highlands for over a decade and who had relationships but did not describe them as friendships. The difficulty of 'breaking into' the rural way of life and being accepted may increase isolation and a lack of belonging. Also, from a gender perspective, these women may be unable to form meaningful relationships that may go against both their social tendencies. The transferability of this experience to people and cultures in new to any area, rural or urban, is likely, as pointed out by a discussion with one practitioner (Practitioner's Workshop 2008). Outreach in rural areas and also to 'new comers' in general may be crucial in helping to establish and define

friendships, networks and community and create an acceptance amongst each other.

Minority population

Interestingly, the only black, minority, ethic representation from these focus groups was in the rural setting. The minority population representation was not specifically sought out for this research. The discussion here is to simply highlight the potential issues, but does not claim to uncover all of the potential paths in which minority populations experience social networks. However, the importance of improving the understanding of social networks, health and gender cross-cut with culture is highly recognised. The minority women in the research expressed a potential additional difficulty both in rural living and being new to the area. For women, being the minority may add an additional layer to the triple burden and create additional barriers to developing social networks. More generally, for both men and women, it is found that minority populations may experience more hardship and have less overall opportunities which may influence their ability to develop and maintain networks (Ajrouch *et al.,* 2001). In the research carried out for this report, the women identified some difficulties of creating social networks or being able to tap into existing ones, but they attempted to overcome these barriers by being proactive in their membership to networks and by creating their own formal networks. However, overall, minorities may be in great need of social network support because of hardships and exposure to stress from racism or discrimination. Access to support may be limited in times of need because minority networks are often less dense and diffuse and may thus influence their mental health. (Ajrouch *et al.,* 2001). The importance of social networks has been stated previously, however, social networks for the minority population can be significant in contributing to a sense of belonging, the sharing of information, and the establishment of support and trust, all of which can promote mental health.

Challenges of social networks

There were a number of challenges about formal social networks that surfaced during the focus groups. One challenge dealt with membership in the men's groups. The development of one of the men's groups was difficult. Several months were needed to increase the membership to a workable level. Both men's groups mentioned the difficulty of first attending. A member of the group explained that he understood how a group could be overpowering and how it may be difficult to come and mix with the group. The other men's group mentioned the need to 'put on a façade' for the first meetings due to a high amount of anxiety when first attending. The first step was said to be the hardest. However, after the initial introduction and adjustment to the men's groups all the members praised the experience of being part of the group.

The second challenge identified described exclusionary networks expressed by the women's group. Some groups, such as mum and tot groups, were seen as both intimidating and exclusionary. At the same time, other women found their children created opportunities to access groups and meet new

friends. In practice, one of the most challenging aspects may be getting people to take that first step and attend the group or network, but hopefully the benefits of being members to the group will reinforce their attendance. Also, making the group welcoming and varying approaches to include and reach out to different types of people may be beneficial (Practitioners Workshop 2008).

Challenges were also mentioned by the practitioners at the workshop. They expressed the concern of 'negative' networks, which they generally described as those which promote negative behaviour, such as substance use. While addressing such networks may be especially important for young people, adults can also be affected by their membership to these networks. No single, specific approach was determined in these discussions; however, the suggestions to potentially disband the network or translate the network's activities into more positive ones were mentioned. Approaches for adults and young people may likely differ. (Practitioner Workshop 2008).

In the readings on social networks, social support from these networks is found to protect mental health. Even so, it is argued that if women are receiving support from multiple places, they may also be providing support in multiple relationships. If they are in reciprocal relationships, it can create a mental health cost (Bertera, 2005). On the other hand, other studies find an increased number of ties as an increase in the potential for social support, which is beneficial for mental health (Pugliesi & Shook, 1998). Members of the men and women's groups consulted as part of this research also uncovered this complex relationship. On one hand people relationships were thought to be stressful, but participants also identified the benefits of friendships.

Benefits of social networks

In general, members of formal networks, which served as focus groups for the research, had very positive things to say about the formal social networks. Highest on the list was simply meeting new people, forming relationships and making friends. Group members who were mothers simply appreciated an allotted time to get away from their role as care taker and have time to connect with others. Men appreciated the chance to be involved and were cognizant of the group's potential to provide support through conversations and activities within the group. In addition, the development of confidence, trust, and interpersonal skills for all ages was seen as positive consequences of social networks. Some of the men said that the group instilled confidence in them which is then helpful in creating new friends outside of the formal men's network. In the early discussions with practitioners, the need to build individual skills and social networks at the same time was mentioned, implying that you cannot have one without the other. From this research, it seems that individual skills may be a result of being part of social networks. However, when forming or facilitating a group it could be useful to explicitly focus on developing these attributes. For instance, a programme in England identifies building confidence as a key part

of the process in promoting social contact among the elderly (Greaves, 2000). Building these skills and characteristics may benefit an individual's mental health.

The men and women in this research did not believe the number of friends mattered as long as they were good friends. The literature reinforces this by explaining that the perceived quality of relationships may be more important for mental health than size of the social network size (Hintikka *et al.,* 2000; Fiori *et al.,* 2006; Taylor *et al.*, 2000). While this is seen more strongly for women, it has also been described for men's networks. My research and the literature reveal that quality may matter more than quantity. Again, this uncovers the complexity of social networks and relationships. As previously stated, men have a higher chance of better mental health if they have larger networks; however, here the literature is describing the quality to be more influential. It is easy to imagine a situation where a quality friend providing support may be better than the number of friends providing support. Perhaps it is a balance of the two. Measuring the quality of a relationship or understanding a friendship may be difficult for practitioners; however this notion of quality can also be empowering for practice. Large groups with a big profile may not be necessary to make a difference in mental health. Even small efforts may have a big impact on the promotion of mental health.

Many practitioners valued the notion of interdependence rather than dependence or even independence. In their presentation at the practitioner's workshop, the Rock Trust evoked the benefits of promoting an interdependent relationship as one that it is interconnected and reciprocal. Such interdependent relationships underline the true beneficial potential of social networks by encouraging the ability to succeed in relationships, through giving and receiving. In practice, reducing dependence and promoting interdependence and reciprocity may help to eliminate the reliance on professionals and may promote the formation of natural networks. (Practitioners Workshop 2008).

Overall, the benefits of formal networks suggested here is part of a process. Relationships are complex and sensitive and take time to develop and maintain. Supporting people to create formal networks can help develop skills, characteristics and opportunities for expanding their current network or developing informal networks. Practitioners can become a step in this process, which will be discussed later.

Limitations and future research

This research was carried out in order to create awareness and initiate a wider dialogue on mental health, gender and social networks. It is recognised that there are several limitations of this research, which in turn highlight areas for future research. First, due to the use of existing networks, the nature of the focus groups resulted in data pertaining to more formal social networks and less on informal or natural networks. However, general data on informal relationships was discussed and disclosed here including

friendships, relationships with partners, family situations and others. Also, using pre-existing groups allowed the benefits of a network to surface. Exploring the role and processes of natural networks may provide interesting conclusions in relation to its impact on mental health. Furthermore, this sampling did not permit evidence on social isolation or exclusion, since these participants were active in their existing networks. Encouraging networks for those who have less confidence or suffer from a mental health problem or others reasons for isolation needs to be further understood. It is important that such research is undertaken in a cultural context in order for its findings to be applicable in practice.

Given that men and women are not a homogenous group, but are a group that are influenced by differences "based on class, race, culture, ethnicity, sexual orientation, gender identity, age and ability" (Morrow, 2003:8), more research should be carried out examining gender and these different cross-cutting characteristics. Research of this kind would be need to be extensive in order to properly understand gender and other characteristics ability to shape one's mental health.

Perhaps the widest gap in my research, as acknowledge by practitioners, was the implications of negative networks. Negative networks may include "unwanted or aversive contacts, ineffective support and social control to influence unhealthy behaviour" (Fuhrer *et al.,* 1999:78). These networks were believed to reinforce negative behaviour. Negative networks were viewed to be somewhat cyclical and thus the desire to change and eliminate or transform negative relationships must be identified first. Difficulties arise in assisting people to achieve this recognition and then with replacing the negative activity or network (Practitioner's Workshop 2008). Investigating if and how such negative networks influence behavioural, physical and mental health would be beneficial in understanding and addressing such networks, as well as researching those who are in these 'negative' networks and whether or not they find them supportive. And lastly, exploring how and why those who are in a 'negative' network but defy the networks norms may also help in developing an approach to these networks.

Considerations for practice

Mental health improvement may be more effective be keeping gender differences of mental health in mind. Mental health improvement considers the wider determinants of health, and gender certainly influences these determinants and the control men and women have over their overall health. Social networks were used to further understand how the roles women and men have in society influence mental health. Understanding the influence of social networks on mental health contributes to mental health improvements overall aims of promotion of mental health, prevention of mental illness and improved quality of life. Social networks are a strong force that promote positive mental health overall, as seen from the literature and research reviewed in this report.

The process of social networks

This qualitative research emphasised the underlining processes at work with formal networks. These groups were important for developing opportunities to create or expand networks. Also, skills and characteristics important for this development were recognised by these groups, both implicitly and explicitly. Such mechanisms are part of a process that can encourage networks and contribute to the aspects of social networks that promote positive mental health. Organisations and practitioners may promote the formation of both informal and formal networks by playing a role in supporting social networks through the below implications for practice:

- Motivating people to attend networks/groups or getting people 'through the door'
- Creating opportunities for people to make and sustain friendships
- Developing individual skills & characteristics which help promote social networks such as interpersonal skills, confidence, trust, interdependence

Gender and social networks

Considering the affect of gender on social networks may deepen the effectiveness of mental health improvement. Similarities and differences exist between the formation and function of men and women's social networks. Parallels in the quality of relationships, the preference for friends over family and women potentially filling the role of confidant, existed in both this research and research elsewhere. Variation between their networks arose in differing societal roles, network composition and ideas about relationships with the opposite sex. Considering gender and social networks, implications for practice include:

- Supporting men in building networks
- Supporting women in harmonising family, work and social life

Isolation and social networks

Promoting social networks for 'hard to reach' people or those in isolation remains difficult. Looking at why a person may not be participating in a service with a gender perspective may provide increased insight. Research shows that men may be at more risk of isolation than women (Vandervoort, 1999). In a U.K. study on isolation later in life, participants were asked what they felt would decrease isolation. Their responses highlighted the need to enhance social networks, promote a sense of community and address barriers that may prohibit participation, such as transport and finances. (Victor *et al.,* 2007). Continuing to develop programmes or services that have an implicit focus on mental health may address some of the issues raised by Victor and colleagues, while promoting mental health. Yet the participants in my research suggest that encouraging people to attend a formal network may be the greatest challenge. Different communities and individuals will require different approaches, however if gender is taken into consideration it may help form more successful groups. This and other research shows that men are often more inclined to task oriented groups, whereas women may enjoy

sessions that promote dialogue. Additionally, the focus groups in this research highlighted the importance of one member of the social network extending an invitation to a potential new member. Further research on positive social groups may help in transferring these aspects to those in isolation (Practitioner's Workshop 2008).

Cultural and structural shift

While these implications for practice may be fairly concrete, there is a need to address cultural values and norms. Practitioners suggested that formal social networks may have an important role in supporting people to deal with personal difficulties that arise from wider social issues, be it health or other areas which impact on health. This would indicate that social networks should be established and encouraged to support people at key stages of life course in preparation for difficulties that may arise (Practitioner's Workshop 2008).

Social networks are the foundation of many approaches to improving and promoting mental health, such as physical activity, creative arts and continuing education (Friedli *et al.,* 2007). With a contextual understanding, encouraging approaches that promote social networks through policy may have benefits for both individuals and the population. Making the benefits of these approaches and social networks more widely known and supported by policy could have a wide impact on mental health improvement in Scotland.

Conclusion

Understanding all aspects of a population that have potential to influence the population's mental health is important for a true approach to mental health improvement. Gender is a characteristic which is often overlooked or not fully considered, but one which can have a deep impact on mental health. This report investigated ways in which men and women experience health and mental health differently through looking at existing literature and using qualitative data to examine relationships and networks. Such sources highlight the complex and intertwined nature of mental health, gender and social networks, as they interact with one another and also with other outside mechanisms. Awareness of the differences between men and women's networks can help promote social networks and thus generally promote mental health. Specific considerations for social networks and mental health may include encouraging men to increase the number of people in their network or promoting a woman's network by developing skills to balance work, family and social life. The preference for confiding in friends over family can be used by practitioners, who may typically encourage friendship networks. In addition, practitioners can support social networks by contributing to the process of social networks directly, through initial formation and facilitation, and indirectly through encouraging skill development, confidence building and reciprocal support among participants. In all approaches to promote mental health, whether explicit or implicit, issues of gender should be considered in practice. This report hopes to spur

professionals to consider the implications of gender on mental health and social networks in their own work and expand such ideas in their wider professional network.

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