Clues in the history include frequent emergency room visits, delay in seeking treatment, an inconsistent explanation of injuries, missed appointments, repeated abortions, late initiation of prenatal care, medication noncompliance, inappropriate affect, overly attentive or verbally abusive partner, apparent social isolation, and reluctance to undress or difficulty with examination of genitals or rectum. Common presenting complaints include somatic symptoms (e.g., chronic pain, headaches, irritable bowel symptoms), psychological symptoms (e.g., depression, anxiety, panic disorder, posttraumatic stress disorder, substance use), and gynecologic symptoms (e.g., STIs, chronic pelvic pain, unintended pregnancy). After identification, a woman may be referred to a mental health provider or social worker.

Psychiatric Issues

Fewer than one half of people who meet the diagnostic criteria for psychological disorders are identified. Patients are also reluctant to seek professional help. Only two of every five people with a mood, anxiety, or substance use disorder seek assistance within a year of onset of the disorder. Overall rates of psychiatric disorders are almost identical for men and women. However, substantial gender differences exist in the rates of common mental disorders, including depression, anxiety, and somatic complaints. In the United States, the estimated lifetime prevalence is 21% for women and 13% for men. Depression is the most common women's mental health problem, and it may have a worse prognosis for women because it is often more persistent than in men.

Advances have been made in understanding mood disturbances during specific phases of women's reproductive lives, specifically during the postpartum period, the premenstrual phase (i.e., premenstrual syndrome and PMDD), and the menopausal transition. Depression occurring at these times may represent a specific biologic response to the effects of hormonal fluctuations in the brain and may require different treatments from depression unrelated to these periods. For treating PMDD, SSRIs, oral contraceptives, alprazolam (a benzodiazepine), and GnRH agonists are effective in some women.

The disability associated with mental illness is worse for individuals with three or more comorbid disorders. Women are more likely than men to have comorbid conditions, including anxiety disorders, eating disorders, and somatization. Gender-specific risk factors for common mental disorders that disproportionately affect women include gender-based violence, low income and income inequality, low or subordinate social status, and the responsibility as caretaker of others. The high prevalence of sexual violence against women correlates with the higher prevalence of post-traumatic stress disorder (PTSD) among women than men. Somatization disorders are diagnosed almost exclusively in women. Lifetime prevalence is 0.2% to 2% if strict criteria are used. Somatoform disorders are associated with significant disability and a significantly greater number of clinic and emergency room visits than for other psychiatric diagnoses. There seem to be genetic and environmental contributions to risk.

Generalized anxiety disorder and panic disorder are about twice as prevalent among women than men, with lifetime prevalences of 5% and 3.5%, respectively. Although there is a higher prevalence of social anxiety disorder among women than men, more men may seek treatment for the disorder. Social expectations and gender roles may play a role in this difference.

More than 90% of eating disorders, anorexia nervosa, and bulimia occur in women. Approximately 0.5% to 1% of women between the ages of 15 and 30 years have anorexia, and about 1% to 3% of women have bulimia. There is a strong association between eating disorders and mood disorders, particularly depression. There are no marked gender differences in the rates of severe mental disorders such as schizophrenia and bipolar disorder, which affect less than 2% of the population.

Accessing mental health care is different for men and women. Women are more likely to seek help from and disclose mental health problems to their primary health care physician, whereas men are more likely to seek specialist mental health care and are the principal users of inpatient care. Evidence exists for possible gender bias in the treatment of psychological disorders. Physicians are more likely to diagnose depression in women than men, even when they have similar scores on standardized measures of depression or have identical symptoms at presentation. Women are more likely to be prescribed mood-altering psychotropic drugs.

Coronary Artery Disease

There are significant gender differences in the epidemiology and clinical manifestations of CAD. CAD remains the leading cause of death for men and women, but since the mid-1980s, more women than men die each year of this disease. Women with CAD tend to be diagnosed at a later age (approximately 10 years later) than men. Most CAD in women occurs postmenopausally, when estrogen levels decline. Estrogen increases levels of protective HDL cholesterol, which may affect atherosclerotic plaque progression and regression. Estrogen may also be beneficial due to its vasodilatory, antiinflammatory, and antioxidative properties.

Women with CAD are more likely than men to experience atypical symptoms, such as fatigue, abdominal pain, indigestion, nausea and vomiting, and shortness of breath. These nonclassic symptoms may partially explain why women tend to seek health care later than men. Even when women seek health care, they have a longer time to diagnosis and a longer time to medical intervention than men. Women are also more likely than men to have sudden cardiac death at presentation. They are less likely to receive proven effective therapies, such as β-blockers, aspirin, thrombolytics, and statins, and they are less often referred for invasive testing and coronary artery bypass grafting (CABG). Women are also more likely to die after a myocardial infarction and CABG compared with men.

Black and Hispanic women have a higher prevalence of cardiovascular disease risk factors than white women, including hypertension, cigarette smoking, sedentary lifestyle, hypercholesterolemia, diabetes, and obesity. Although some of these differences may be genetically based, others are likely influenced by behavioral, cultural, and psychological factors. Women of lower SES, regardless of race, have a higher prevalence of cardiovascular risk factors than women of higher SES.

Racial differences exist in the management of myocardial infarction. Black women are offered reperfusion therapy and coronary angiography at lower rates, and in-hospital mortality rates are higher compared with those of white women.

Patient factors and physician factors may contribute to the observed clinical differences in CAD between men and women. Women may delay their own care because they are caretakers.