Culture and Women's Mental Health

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Abstract

Epidemiological studies across countries and cultures have consistently demonstrated higher prevalence of common mental disorders like depression and anxiety among women. However, psychiatry with its biomedical perspectives employs diagnostic criteria, which uses symptom counts sans context, identifies mental disorders, and suggests individual treatments. The failure to acknowledge the role of the psychosocial, cultural, and economic contexts in producing mental distress and ill health among girls and women in patriarchal societies suggests poor understanding of the complex stressors on one hand and the lack of supports and opportunities available to half the world's population on the other. Psychiatric diagnostic systems should elicit and understand the person's context and take into account the psychosocial and economic stress, supports, and coping while

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attempting to empower people. Medicine and psychiatry, nested within capitalistic political and economic systems, need to advocate public health approaches to reducing mental distress and ill health among girls and women. All policies and programs should be viewed through the "gender lens" in order to provide gender justice to girls and women in the near future.

Keywords
Mental disorders · Depression · Anxiety · Gender · Women · Mental health

Introduction

Psychiatry, with its biomedical framework, perspectives, and models, postulates central nervous system etiology and pathology for mental disorders, suggests diagnostic criteria, offers differential diagnosis, and recommends psychotropic medication. In addition, biomedical psychiatry, in order to increase the reliability of diagnosis, emphasizes symptom counts, checklists, and operational criteria while dismissing the person's context. Nevertheless, mental health and illness are significantly influenced by environmental and societal factors. Cultural factors have been shown to affect the prevalence, clinical picture, health-seeking behavior, course, and management of mental disorders. This chapter discusses the issues related to culture and women's mental health, distress, and illness.

Women and Mental Ill Health

Literature is replete with evidence that women suffer significantly higher levels of mental distress and ill health. Studies have consistently demonstrated higher rates of anxiety and mood disorders among women than men (Kuehner 2003; Pigott 1999). Depression has been found to be significantly higher in the lives of girls and women living under social adversity and cultural degradation (Patel et al. 2006). Gender combined with poverty further increases the risk of common mental disorders possibly through the experience of insecurity and the risks of violence and physical ill health (Kleinman 2003). Psychotic presentations and eating disorders are also reported to be more likely to develop in women as compared to men following assault of any kind (Jenkins and Good 2014).

The World Health Organization acknowledges higher rates of common mental disorders – depression, anxiety, and somatic presentations – which affect approximately one in three people in the community and constitute a serious public health problem. Unipolar depression is twice as common in women and is much more persistent in women than men (World Health Organization n.d.-a, b).

The World Mental Health Surveys examined time-space (cohort-country) variation in gender differences in lifetime *The Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, across cohorts in 15 countries in Africa, the

Americas, Asia, Europe, the Middle East, and the Pacific (Seedat et al. 2009). A very large number of community-dwelling adults ($n = 72{,}933$) were studied in face-to-face household surveys using standard assessments. Women had more anxiety and mood disorders than men, and men had more externalizing and substance disorders than women in all countries and cohorts. The surveys also documented significant narrowing in recent cohorts for major depressive disorder and substance disorders, which was significantly related to temporal (major depressive disorder) and spatial (substance disorders) variation in gender role traditionality (Seedat et al. 2009).

Women and Physical Health

While there has been significant improvement in the health, education, and employment status of women in many low-income and middle-income countries over time, the health indices for girls and women compare much less favorably with those for boys and men. For example, a detailed analysis of national and regional data for India shows that there are gender differentials in many indices, with data disaggregated by gender, showing far greater improvement for males than for females (Government of India Ministry of Health and Family Welfare n.d.; The Million Death Study Collaborators 2010; Chandran et al. 2002). The perinatal mortality rate, infant mortality rate, and under-5 mortality rate are poorer for girls. There is evidence of feticide and infanticide of girls. They are often malnourished and brought to hospital later in their course of illnesses than boys. The birth of a girl and failure to conceive a boy are significant risk factors for postpartum depression (Jacob et al. 2006). The suicide rate among young women is about three times that seen for young men (Aaron et al. 2004). Violence against women and girls is common. Women and girls have lower adult literacy rates, school enrolment, and attendance figures. The long walk to school with its associated fear for physical safety, the lack of toilets at schools, the small number of women teachers, and the second-class status of the girl child contribute to these lower rates (Chandran et al. 2002).

Social Determinants of Health

It is widely recognized that the determinants of health are social and economic rather than purely medical (Commission on Social Determinants of Health, World Health Organization 2008). The poor health of women, their social exclusion, and the steep social gradient are due to the unequal distribution of power, income, goods, and services in patriarchal societies. The structural determinants of daily life contribute to the social determinants of health and fuel the inequities in health between girls/women and boys/men. Viewing health in general as an individual or medical issue, reducing population health to a biomedical perspective, and suggesting individual medical interventions reflect a poor understanding of issues. Although the short time lag between the (absence of) medical intervention and the health outcomes stands out as causal, it is the longer latent period and the hazier but ubiquitous and dominant

relationship between patriarchy and culture which have major impacts on outcome. Failure to recognize this relationship and the refusal to tackle these issues result in poorer health standards of the girls and women. Tradition and culture maintain their stranglehold on inequality. Poverty and social exclusion have a multiplicative effect on the social determinants of health with those at higher risk for diseases also having a higher probability of being excluded from healthcare services.

Sociocultural Risk Factors

There are several sociocultural factors that disproportionately disadvantage women and contribute to their emotional ill health. Patriarchal attitudes that have been prevalent for centuries and continue to exist have contributed to this state with women being conferred a subordinate social status and rank (Commission on Social Determinants of Health, World Health Organization 2008). Sexism present everywhere may manifest differently, for example, in poor countries through the denial of educational opportunities to girls and in more affluent countries in the form of unequal pay and discrimination in the political arena. The interrelated issues suggest that the etiology of many mental health "disorders" in women may be considered the diagnosis of the social situation rather than an ailment of the individual (Jenkins and Good 2014). Sociocultural factors which contribute to mental distress and illness are briefly highlighted.

Employment: Job opportunities are considerably restricted for women despite the improvements over the years. There remains inequality with respect to wages in many areas of employment and arenas resulting in women receiving a lower-income relative to men and women being overrepresented in low-income, low-status jobs (Commission on Social Determinants of Health, World Health Organization 2008). This results in women remaining financially dependent on their spouse or other males. The socioeconomic disadvantage also results in women being unable to access necessary treatment.

Women's work at home, because of its invisibility, is rarely recognized, although they work for roughly twice as many hours as men. Technological progress in agriculture and the shift from subsistence to market economies in many low-income and middle-income countries have had a dramatic negative impact on women, cutting them out of employment as many women are unskilled and lack education (Commission on Social Determinants of Health, World Health Organization 2008). Child labor among girls and unequal wages for women for similar work are common. Working women of all segments of society across countries and cultures face various forms of discrimination, including sexual harassment. Women's work is also socially devalued, and autonomy in decision-making related to their life rarely exists for the majority of women particularly in low- and middle-income countries.

Societal roles: Society-imposed gender-based roles have resulted in women being considered the primary family caretakers, responsible for the care of all others including the children, men, and other dependent members. Given this unremitting

responsibility for the care of others, the woman becomes the chronic giver, overworked, and under greater stress (Malhotra and Shah 2015). The personal needs of the woman often remain unmet, as society has deemed their primary responsibility to be toward others rather than to themselves. This constant and intensive caring role can affect the woman's emotional, physical, and social health. Societal expectations of women with regard to their physical appearance result in a greater tendency for body shame, rumination, and eating disorders. In some cultures, the woman is considered responsible for the gender of her child and may be blamed for producing daughters rather than sons resulting in depression in the postpartum period (Chandran et al. 2002).

Multiple roles: Women are often required to juggle multiple roles – they may be mothers, partners, and carers, running a household as well as doing paid work. Even though the number of women working outside the home has increased over the years, this does not relieve them from their domestic duties, which remain invisible, nor does this change their social position significantly.

Health status: The woman's secondary status affects her overall health due to unmet nutritional needs, overwork, lack of adequate rest, and leisure (Jacob et al. 2006).

Violence: The high prevalence of emotional, physical, and sexual violence that women are continually exposed to results in women being in a constant state of vulnerability and subject to negative life experiences. Women are preferentially exposed to abuse such as human trafficking, genital mutilation, forced and early marriage, and honor crimes, which result in significant humiliation and emotional distress.

Decision-making: Making decisions, regarding choice of partner, contraception, timing and number of pregnancies, etc., are often out of the woman's control in low- and middle-income countries which are patriarchal societies (Jacob et al. 2006). The anxiety regarding an unwanted pregnancy can result in significant stress.

Stereotypes: Medical diagnoses are prone to stereotypes. Thus, though a man and woman may present with similar symptoms, the notion that women are more predisposed to emotional distress and depression makes them more likely to earn a mental illness label as compared to a man, when all that the woman is experiencing is a difficult life situation.

Treatment issues: Women are not always taken for treatment of mental illness or may be taken late, contributing to a poorer outcome. She may be abandoned by the spouse and sent back to the marital home, thus, subjecting her to the double stigma of mental illness and marital separation (Jacob et al. 2006; Thara et al. 2003a, b).

Gender Role Hypothesis

A variety of biological, psychosocial, and biopsychosocial hypotheses have been postulated to explain the consistent evidence of higher rates of common mental disorders (depression, anxiety, and somatic symptoms) and the lower rates of substance use in women, which have been documented across countries and

cultures. However, the narrowing of gender differences in cultures and cohorts (Seedat et al. 2009) has refocused interest in the gender role hypothesis, which asserts that gender differences in the prevalence of mental disorders are due to differences in the typical stressors, coping resources, and opportunity structures for expressing psychological distress (Pape et al. 1994; Thoits 1986). The different stressors, psychological and social resources and supports, and the different culturally accepted ways of expression between men and women result in differences in mental health, distress, and illness across time, region, and cultures.

Evidence of decreasing gender differences in depression and substance use has been found largely in countries in which the roles of women have improved in terms of opportunities for employment, access to birth control, and other indicators of increasing gender equality (Seedat et al. 2009). Trends in countries in which gender roles have been more static or during historical periods when gender role changes have been small have failed to document a reduction in gender differences in depression or substance use supporting the gender role hypothesis (Seedat et al. 2009).

Explaining the Link

Culture is broadly defined as “shared symbols and meanings that people create and recreate in the process of social interaction” (Jenkins and Barrett 2004). Culture shapes experience, interpretation, and action and influences how people cope with everyday problems and more severe types of adversity. Gender is a dimension of culture and influences illness experience as well as societal roles, rules, and expectations (Jenkins 2004). There are conspicuous gender differences that are found in the patterns of mental distress and illness, many of which are socioculturally determined. According to the World Health Organization, “gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks” (World Health Organization n.d.-a). This definition makes it evident that, across the globe, women are at a disadvantage.

Gender injustice is often viewed in the sociocultural context and usually in terms of social outcomes. However, analysis of health data clearly documents the importance of gender and its impact on women’s health. Women are the largest discriminated group in most countries. This results not just in adverse social outcomes but also unfavorable health outcomes. Social determinants have a significant impact on the health of girls and women. Viewing the health of women in general as an individual or medical issue and suggesting individual medical interventions reflect a poor understanding of problem. Reducing public health related to women to a biomedical perspective is a major error of the public health movement. Tradition and culture maintain their stranglehold on gender inequality. Debates on gender equality are often reduced to talking about culture, tradition, and religion. The prevalent

patriarchal framework places an ideological bar on the discussion of alternative approaches to achieve gender justice for girls and women. The failure to recognize this relationship and refusal to tackle these issues result in poorer health standards of girls and women.

The social construction of gender in patriarchal societies is cardinal to understanding mental health and distress (Andermann 2010). Patriarchy in practice is a form of structural violence impacting the lives of woman and responsible for suboptimal and poor social, economic, and health outcomes and gender injustice (Jacob 2015a).

Many psychiatric diagnostic labels currently employed in clinical practice (e.g., major depression, generalized anxiety, panic, phobia, post-traumatic stress disorder) assume pathology within individuals even when the problems are in their social environments. Women living in patriarchal societies face a variety of stressors within and outside their homes. Domestic abuse and violence, sexual harassment, and rape, common in patriarchal cultures and often causal, are ignored by the current classificatory systems, which focus on symptom counts sans context (Jacob 2015b). Women, sexual, religious, and ethnic minorities and lower castes (in the Indian subcontinent) who live under continued threats of violence often receive labels, which pathologizes them rather than focus on the abnormality of their environments and their coping responses to continued and severe threats.

Managing Gender-Related Mental Health Challenges

It is evident that women's mental health is influenced by a variety of sociocultural factors, which need to be addressed in order to effectively deal with the problem, rather than hoping to improve it by focusing solely on the individual's personal or lifestyle risk factors or through pharmacotherapeutic interventions. Psychiatry, despite its biomedical formulations, should examine the context and focus on psychosocial interventions to address psychological, social, and economic stressors, environmental supports, and coping strategies. The medicalization of all psychosocial distress, as currently practiced, needs to be replaced with a more holistic approach to psychiatric presentations in medical practice (Jacob 2010). Diagnostic labels like acute and chronic adjustment problems, which focus on problems of living, environmental stressors, and coping, should be preferred to diagnostic heads like depression and anxiety, which provide an illusion disease. The psychiatric framework should make a theoretical shift from a "diagnosis-drug treatment approach" to a broader framework of "caring for illness," understanding illness in context, and taking care of the person who is sick (Jacob 2010; Jacob and Kuruvilla 2017; Kuruvilla and Jacob 2019). Formulations, which focus on healing, often remain at a subtheoretical level, are learnt by trial and error and require long years of experience, and, consequently, need to be emphasized and theorized. Contexts should not only influence medical and psychiatric practice; they should be able to change its theory (Jacob 2017).

The UN Program on Population and Development and Inter-Agency Task Force (United Nations Population Information Network 2001) has suggested that there are five components that are required for women's empowerment: "improving the women's sense of self-worth; ensuring their right to have and to determine choices; the right to have access to opportunities and resources; the right to have the power to control their own lives both within and outside the home; and the ability to influence the direction of social change to create a more just social and economic order, nationally and internationally."

Education provides women an awareness of their rights and resources, the capability to fight exploitation and injustice, and better chances of economic independence. Effecting changes in societal attitudes so that women can have sufficient autonomy to make decisions that affect their lives; ensuring equal access to employment; providing material resources such as healthcare, adequate food, water, and shelter for them to be able to support themselves; and ensuring that they are able to receive necessary psychological support are important strategies.

The World Psychiatric Association (WPA) has called for the "elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual, orientation, or religious beliefs" (Stewart 2006). It is imperative to ensure appropriate criminal justice responses to violence against women. Political and legal will is necessary to establish policies that are woman friendly and that address women's mental health needs and concerns while taking into account sociocultural norms that affect them. Interventions that focus on the social and economic determinants of mental health such as social inclusion, access to economic resources, and freedom from discrimination and violence have been shown to improve women's mental health (Kermode et al. 2007). Women with high levels of social support have been shown to be less likely to experience depression (Dasgupta et al. 2013).

While gender equality and justice are among the United Nations Millennium Development Goals, their implementation in many low- and middle-income countries has been slow and patchy. Issues related to gender equality are not adequately mainstreamed in many countries. Discussion of gender is usually confined to Goals 3 and 5, which are gender equality and maternal mortality. Women are cast only in the role of victims, rather than as equal partners in development. The social, economic, and cultural contexts, the most significant predictors of women's health, are barely mentioned.

The spirit of egalitarianism enshrined in many national constitutions per se has not and will not result in equality of social and health outcomes for all people. There is need to change social structures. The many small moments of justice cannot overcome the large contradictions in patriarchal societies. Liberals, by definition, can identify the issues but do not actively seek fundamental shifts in political power or enthusiastically champion changes in social mores. They are also part of the tyrannical social order. Systemic injustice requires much more than a change of heart; it requires changes in social structures. Social injustice is killing people and mandates the ethical imperative of improving the social determinants of health (Commission on Social Determinants of Health, World Health Organization 2008).

Conclusion

Women's well-being is thus "not solely determined by biological factors and reproduction, but also by the effects of workload, nutrition, stress, war, migration" (Van der Kwaak et al. 1991). The origins of much of the pain and suffering particular to women can be traced to the social circumstances of their lives. While it is essential to identify and strengthen existing individual sources of strength and resilience to help women cope in the face of prevailing cultural situations (Scheper-Hughes 2008), to truly deal with the problem at its root requires efforts on a global scale to enhance the status of women. This requires legal and political means to encourage changes in attitudes toward women, to ensure education and economic empowerment and improvement in social and mental health services, and to ensure not only equal opportunities but also on achieving equal outcomes (Scheper-Hughes 2008).

The benefits of making such changes are demonstrated by the decreasing gender differences that have been observed in disorders such as depression and substance use in countries that have provided greater employment opportunities for women, access to birth control, and other resources to help combat stress (Seedat et al. 2009).

Social interventions should form the core of all health and prevention programs as individual medical interventions have little impact on population indices, which require population interventions. The major barrier to mainstreaming gender justice and to scaling up effective interventions is gender inequality based on sociocultural issues (Jacob n.d.). The systematic discrimination of girls and women based on culture and tradition needs to be tackled if interventions have to work. Many researchers and activists are no longer convinced that we can succeed in improving women's health or status unless society attempts to confront its gender bias openly. For too long we have been refusing to discuss women's issues explicitly with society. It would appear that nothing short of a social revolution would bring about an improvement in the health of Indian women.

Many approaches have been suggested. They will all need to include methodologies, which examine, understand, and confront gender discrimination in social, cultural, and religious spheres (Jacob n.d.). Legal solutions enforcing gender justice are equally necessary, and monitoring the implementation of legislation is mandatory.

The magnitude of the inequality related to health is often downplayed even within medical circles (Jacob n.d.). The second-class status of women in many societies persists, and women's perspectives continue to be missing, marginalized, or ignored. There is a definite need to engage communities and the population as a whole in a debate to challenge traditional stereotypes and accepted social norms. Programs to achieve gender equality should not only focus on the provision of equal or greater opportunities for women. They should also concentrate on achieving equality in gender outcomes within a reasonable timeframe. Outcomes, in general, and health outcomes, in particular, are measurable with a much greater degree of accuracy than opportunities.

The United Nations Women's new flagship report, "Turning promises into action: Gender equality in the 2030 Agenda for Sustainable Development" (United Nations

Women n.d.), provides a comprehensive and authoritative assessment of progress, gaps, and challenges in the implementation of the Sustainable Development Goals (SDGs) from a gender perspective. It monitors global and regional trends in achieving the SDGs for women and girls based on available data and provides practical guidance for the implementation of gender-responsive policies and accountability processes. It lays the basis for robust, gender-responsive monitoring of the 2030 Agenda for Sustainable Development. The report:

(i) Shows how gender equality is central to the achievement of all 17 SDGs and arguing for an integrated and rights-based approach to implementation
(ii) Explains gender data gaps and challenges for robust monitoring and establishing starting points and trends across a range of gender-related indicators based on available data
(iii) Provides concrete guidance on policies to achieve two strategic targets under SDG 5 (violence and unpaid care) and outlining how these policies are synergistic with other goals and targets
(iv) Sets an agenda for strengthening accountability for gender equality commitments at global, regional, and national levels (United Nations Women n.d.)

All plans and projects within community programs should be assessed using the "gender lens" in order to achieve gender justice for women (Jacob n.d.). These programs will have to cover the social context of home, school, workplace, law, and politics in order to improve women's health. There is a need to challenge the normalization of gender discrimination in many countries and cultures. The focus should be on public health approaches to change social and cultural perspectives with the aim of primary prevention of discrimination while continuing medical interventions for early diagnosis and management of the medical consequences. There is a need for aggressive gender justice in order that women can achieve equal health and social status in the near future.

Cross-References

► Depression, Anxiety, and Physical Morbidity in Women
► Interpersonal Violence and Perinatal Mental Health
► Women's Political and Economic Participation

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