

Culture and the social construction of gender: Mapping the intersection with mental health

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Abstract

The social construction of gender is an important concept for better understanding the determinants of mental health in women and men. Going beyond physical and physiological differences and the traditional biomedical approach, interdisciplinary study of the complex factors related to culture and society, power and politics is necessary to be able to find solutions to situations of disparity in mental health, related to both prevalence of disorders, availability and response to treatment. Gender inequality continues to be a source of suffering for many women around the world, and this can lead to adverse mental health outcomes. This review focuses on developments in the literature on culture, gender and mental health over the past decade, focusing on themes around the social construction of gender, mental health and the media, a look at cultural competence through a gender lens, gender and the body, providing some examples of the intersection between mental health and gender in low-income countries as well as the more developed world, and the impact of migration and resettlement on mental health. At the clinical level, using a bio-psycho-social-spiritual model that can integrate and negotiate between both traditional and biomedical perspectives is necessary, combined with use of a cultural formulation that takes gender identity into account. Research involving both qualitative and quantitative perspectives, and in many cases an ethnographic framework, is essential in tackling these global issues.

Introduction

The social construction of gender is one of the underpinnings of mental health. Going beyond physical differences in brains and bodies, an exploration of the areas of culture and development, across the lifespan and across the globe, can provide some context for a better understanding of mental health, and illness, and the complex and varied social worlds that make up the lives of women and men, families and communities. A recent World Health Organization report on the status of women's health states that 'despite considerable progress over the past two decades, societies are still failing women at key moments in their lives. These failures are most acute in poor countries, and among the poorest women in all countries. Not everyone has benefited equally from recent progress and too many girls and women are still unable to reach their full potential because of persistent health, social and gender inequalities and health system inadequacies' (Chan, 2009). As this special journal issue of the *International Review of Psychiatry* is structured around papers on gender differences in a variety of specific mental disorders, this paper will take a broader anthropological approach and review some

of the social and cultural factors impacting on mental health and well-being. Selected references were sourced from PubMed, Google Scholar, the University of Toronto Libraries Portal, and mass media (mainly newspapers and online news sources) using search terms including: social construction of gender, social determinants of mental health, women's mental health, cultural psychiatry and cross-cultural mental health. Emphasis was placed on publications in the past decade, 2000–2010.

Gender and Current Events: Links to Mental Health?

While writing this paper, I became more aware of a very large number of stories about gender issues on the front pages of Canadian newspapers. The more I read, the more ubiquitous it seemed. Having just wrapped up the 2010 Winter Olympics in Vancouver, Canada, the games were still on the minds of many, even those like myself not usually interested in sports. The debate about the Canadian women's hockey team, who celebrated their gold medal victory on the ice with beer and cigars, almost

prompted an IOC investigation for ‘inappropriate behaviour’ (Canwest, 2010; Keating, 2010). Would the same scrutiny exist for the men’s team victory party? Likely not, as ‘locker room culture’ still seems more acceptable for men. Questions lingered around whether female Olympic athletes should be featured in the swimsuit edition of *Sports Illustrated* (Reynolds, 2010).

A few days later, the Prime Minister’s office caused an uproar when it was suggested that perhaps the words of the Canadian national anthem, ‘true patriot love in all our sons command’ should be changed to something more gender neutral (Brennan & Campion-Smith, 2010). In the end, they withdrew the proposal. The Prime Minister, who is president of the G8 countries in 2010, also made a promise to champion a major initiative in women and children’s health in the world’s poorest regions while hosting the meeting in Canada this summer (Delacourt, 2010). It sounded good on paper. However, this led to much criticism, from those believing that the government needs to focus equally on maternal and child health issues at home, including abortion and contraception as part of maternal health initiatives, as well as poverty-related issues in Canada, particularly among the aboriginal population, recently reported to have a 31-times higher rate of tuberculosis than the Canadian born, non-aboriginal population (Ljunggren, 2010) as well as high rates of food insecurity in 70% of homes with preschoolers (Luo et al., 2010). Stephen Lewis, human rights advocate and HIV expert was quoted as saying: ‘None of the spectrum of women’s rights and issues is encompassed in this announcement. It doesn’t include sexual violence, child marriage, sexual trafficking, female genital mutilation, economic autonomy, political representation, land rights or inheritance rights. It includes none of the panoply of women’s issues which consign women to subordinate positions around the world’ (Zerbisias, 2010).

Following in the footsteps of France, Quebec education authorities recently banned a Muslim woman from attending classes while wearing a *niqab*, religious veil (Peritz, 2010). At the same time, a story about record numbers of Saudi students being sponsored to study in Canada was reported (Church, 2010), although women were only allowed to attend if they were accompanied by a male chaperone, usually a husband or brother.

From all these recent events, questions arise about the universality of women’s lives: Is the culture of women universal? What is the role of visibility of women? What is the link between these very different social situations, cultural backgrounds and women’s mental health? Or rephrased on a lighter note, if gender differences exist even for symptoms of the common cold (Macintyre, 1993), one of the studies

encountered during this literature review, what hope do we have for understanding the myriad social and cultural factors related to gender and mental health? And why do these problems continue to persist over time when the links between social issues, gender and mental health have clearly been identified around the world?

The situation of women in many parts of the world remains complex. The link between the woman in the *niqab* incident and mental health, while not direct cause and effect, is clear. As reported in the newspaper, when she saw the Quebec official coming to remove her from the classroom, the woman started to cry. In her words, ‘It wasn’t fair for them to ask me to leave the exam... I feel like the government is following me everywhere’ (Peritz, 2010). Caught in this situation, she felt depressed and was unsure about completing her language lessons, necessary steps for integration into her host society, saying ‘I’ll just stay in my house. This will solve my problem’ (Peritz, 2010). Regardless of which side of the debate will win this time, the side calling this traditional garb an ‘ambulatory prison’ or those advocating for greater acceptance of diversity and cultural norms, and decreasing social isolation among new immigrants, the stress caused by these situations is harmful to everyone in a healthy society, especially those most closely affected. It is ironic that by having her own words cited on the front page of a national newspaper, this deflates the arguments of education officials who claimed that she could not learn a second language properly, and thus did not belong in class, if her mouth could not be seen.

The discussion around this incident, and similar instances from other countries, could be the topic of an entire volume. In fact, studies from Canada, Australia and Sweden have more rigorously linked the social construction of anxiety, depression and concepts of wellness in the popular media through discourses in newspapers and women’s magazines (Bengs, Johansson, Danielsson, Lehti, & Hammarström, 2008; Dowbiggin, 2009; Gattuso, Fullagar, & Young, 2005; Johansson, Bengs, Danielsson, Lehti, & Hammarström, 2009; Roy, 2008). I would now like to shift this discussion to introduce the need for culturally competent clinical practice with a gender focus.

How does cultural competence relate to gender and mental health?

With globalization, migration and situations of increasing social complexity, the ability to work comfortably in situations of cultural diversity has become an essential part of clinical practice for mental health professionals (Andermann, 2006). Concepts of cultural competence go far beyond

ethnocultural boundaries to include many interpersonal differences, including: gender identity, age and generational identity (for example youth being considered a sub-culture), social class, education level, professional identity, and religious identity (Andermann & Lo, 2005). Cultural competence can be broken down into key areas of knowledge, attitudes, skills and experience. It can then be further divided into specific competence, where one has in-depth knowledge of specific reference groups, and generic competence, where one uses a set of generic principles in order to work effectively with a myriad of less familiar groups in a culturally sensitive way (Lo & Fung, 2003). Another important factor relates to recognizing and working with power imbalances as they exist between patient and clinician.

Cultural competence can be viewed at the individual clinical level, the programme level and the institutional level, as well as within the wider society (Fung et al., 2010). Examples of this might be a female community psychiatrist to whom many female patients prefer to be referred for psychotherapy rather than seeing a male therapist (individual level), a specific clinic within a general hospital focused on women's mental health (programme level), a hospital focused on women's health (institutional level) and national legislation protecting the rights of women, minorities or other groups (societal level). Cultural competence should exist at each of these levels, as defined originally by Terry Cross, and widely cited: 'Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations' (Cross, 1988).

A creative treatment manual for mental health in low-income countries, *Where there is no psychiatrist* (Patel, 2003), emphasizes the importance of targeting these different levels: 'the promotion of gender equality, by empowering women to make decisions that influence their lives and educating men about the need for equal rights, is the most important way of promoting women's mental health' (p. 229). Practical suggestions are then offered for health care workers on how to ask about stress at home, ensure follow-up for women, and asking for permission to speak to husbands or family members for collateral history. The manual also addresses larger advocacy issues such as starting community support groups for women as well as providing group psychoeducation.

How, then, to translate this model of generic and specific cultural knowledge, to good clinical use?

The DSM-IV Outline for Cultural Formulation is a five-axis model looking at (1) cultural identity, (2) explanatory models of illness, (3) cultural factors

related to social stressors and supports, (4) cultural factors affecting the relationship between therapist and patient, and (5) overall cultural formulation (APA, 2000). Teaching this model, and finding ways of integrating it into clinical practice has been shown to be a useful teaching tool in psychiatry residency, CME and faculty development programmes (Fung, Andermann, Lo, & Zaretsky, 2008; Lu, Lim, & Mezzich, 1995).

Exploring a patient's explanatory models of illness encompassing both traditional and western beliefs is an important part of the cultural formulation, and can also reflect gender differences. Idioms of distress, health seeking-behaviours and preferences for certain treatments may be different in men and women. One small study of Bedouin Arabs in Israel illustrates this point well, with men found to be more familiar with the biomedical system, and women with the traditional system of healing (Al-Krenawi & Graham, 1999). The study found gender differences in symptom expression as well as patient's understanding of etiology. They conclude that 'biomedical practitioners can learn from traditional healers how to read a client's ecological map, incorporate the family/community in treatment, and communicate in the patient's cultural idiom. In their search for models of traditional/biomedical system integration, scholars should turn to patients themselves, who are currently living such integration' (Al-Krenawi & Graham, 1999).

Some personal disclosure seems appropriate here. When writing a previous review of this area (Andermann, 2006), I had been married for several years, and did not yet have children. Now just a few years later, a mother of two children under the age of three years, I wondered as I prepared for this task how my new role as a parent may influence my perceptions of material in this area, and what new understanding, if any, had been gained. Agreeing to write the chapter while on maternity leave highlighted some of the tensions around balancing work and family faced by working parents. It was interesting reading Ellison's *The Mommy Brain: How Motherhood Makes Us Smarter* (2005) which provided some of the neuroscience behind what she calls a 'baby-boosted brain' and how functioning in the areas of perception, empathy, resiliency, efficiency and multitasking, and emotional intelligence could be improved through the experience of parenting.

Clinically, I had already noticed certain things: a new admiration for the single parents in my practice, and greater appreciation of the well-worn saying 'it takes a village to raise a child'. When these mothers, and sometimes fathers, were also new immigrants or refugees, their situation had added urgency, and the need to link them to social supports became much more important. Despite trying to

maintain therapeutic neutrality, I was at times also more sensitive to the descriptions of child neglect and abuse I encountered in my work, now being able to picture the smallness of a child in a much more immediate way. I also had to deal with the needs of a number of immigrant female patients with severe and persistent mental illness who had strong desires for children of their own, and the ethical dilemmas around providing reality-based family planning and counselling for them, while both they and I were aware of my own expanding family and my need to take time off work.

Part of the reason why I uncharacteristically included a few lines of self-disclosure will become more evident now. In order to practice in a culturally competent manner, one must be aware of one's own identity first and foremost, and to be mindful of what one brings to the therapist-patient dyad. Cross-cultural interactions do not only concern the patient as the 'other', but also implicate our own identities and our practice environment. As highlighted in the DSM-IV Outline for Cultural Formulation (2000), paying attention to all facets of one's identity, including languages spoken, ethnic background, migration history, gender identity, identity within the family, and professional identity will certainly impact on the treatment relationship, and hopefully lead to better understanding and communication, adherence to treatment plans and outcomes. Mnemonics such as the L-E-A-R-N model can be useful in this regard: *Listen* with sympathy and understanding to the patient's perception of the problem, *Explain* your perceptions of the problem, *Acknowledge* and discuss the differences and similarities, *Recommend* treatment, and perhaps most importantly, *Negotiate* agreement (Berlin & Fowkes, 1983). Without this final step, treatment goals cannot be accomplished.

Turning the lens on ourselves as health professionals is another way to study the social construction of gender. In keeping with trends in anthropology to make a systematical study of the familiar, rather than the exotic, ethnographer Tanya Luhrmann in her book *Of Two Minds: The Growing Disorder in American Psychiatry* described the training process of psychiatrists and the development of the rift between the psychotherapies and the pharmacological approach now dominant in North America. With a similar emphasis on the workplace and career development, Sebrant (1999) examined the roles of women working in hierarchical health care institutions, described as 'patriarchal systems where male values were normative'. She explores two concepts of gender system and the logic of personal relationships, and writes that that the hierarchical system 'seems to be self-generating among both women and men' (1999), concluding that women would have

better opportunities in a more flexible and anti-authoritarian work organization. This research brings to mind the concept of different levels of cultural competence described above, and the ways that clinical service, as well as professional identity, can be shaped by the culture of a programme or institution.

Language can be an important barrier to care with new immigrant and refugee populations. Working with interpreters, when language issues are present, is also one of the ways that women's voices can be heard more directly, by avoiding the use of husbands or family members being asked to translate. Cultural consultants, who have insider knowledge of a particular culture, can also provide useful context and collateral information.

Social construction of gender and mental health: New research and reviews

Although this is an area of almost indefinite scope, a selection of recent studies is reviewed below investigating the links between social and cultural factors, gender and mental health.

The *Lancet* Series on Global Mental Health (2007) addresses issues around both sexual and reproductive health, as well as maternal and child health. Women are found to be at higher risk of common mental disorders, with a male to female sex ratio of 1.5 to 2 (Prince et al., 2007). The World Health Organization estimates that 73 million women worldwide experience a major depressive episode each year (WHO, 2009). However, they report a large discrepancy between women receiving treatment for moderate to severe mental illness based on where they are living: In higher income countries 40% receive treatment versus only 14% in lower income countries. As the most serious outcome of depression, suicide and suicidal behaviours are the most significant public health problem for women and girls worldwide: the fifth leading cause of death in women aged 20–44 years – ahead of road traffic accidents (WHO, 2009). With regard to social factors affecting these very significant numbers, the WHO report states that: 'gender differences in social roles may also play a part in suicidal behaviour. There is evidence in some cultures that social inequality and membership in tightly structured social units, especially patriarchal families, are risk factors for female suicidal behaviour. In China, where suicide is the leading cause of death among adult women in rural areas and where suicide rates of women are higher than those of men, the most significant contributing factors are considered to be severe stress from acute life events and the ready availability of potentially lethal pesticides' (WHO, 2009, p. 54). More needs to be known about

developing effective clinical interventions for this very serious problem.

A review paper on social construction of gender and suicide in developed western societies adopts a social constructionist viewpoint that defines women and men's identities as 'something that is done' as opposed to 'biological sex ascribed at birth according to external genitalia' and where women and men's identity, behaviour and expectations placed upon them reflect socially constructed ideas about femininity and masculinity (Payne, Swami, & Stanistreet, 2008). The authors analyse the links between gender and suicide risk by examining the large body of evidence about the suicidal behaviours of women and men through a range of intermediary variables including: individual and life history variables (methods used in suicidal behaviour, mental illness, substance abuse, health care usage, sexuality); social and community variables (marital and parental status); and living and working conditions (employment and unemployment, socio-economic status). For example, while a history of mental illness is known to be the greatest risk factor for suicide in both women and men, when examined more closely, gender differences, including the type and frequency of mental illness and the likelihood of help-seeking in women and men affect these outcomes. In summarizing the large body of evidence showing the well-known findings that more men die through suicide and more women engage in deliberate self-harm, they report that suicide prevention strategies have remained blind to these differences and that 'public health policies in the West have generally treated gender as an invisible concept' (Payne et al., 2008). Public health policies that recognize the many ways in which gender can affect health-related behaviour are recommended (Hawton, 2000).

In an excellent review paper on gene-environment interactions being linked to higher rates of mental illness in women, Vigod and Stewart (2009) hypothesize that 'women may be particularly vulnerable to the genetic predisposition to depressive symptomatology because many significant life stressors differentially disadvantage girls and women. Discrimination, violence, physical, sexual, emotional, financial abuse and poor working conditions remain problems that differentially affect women worldwide'. They go on to describe how stresses to the hypothalamic-pituitary-adrenal (HPA) axis in infancy and childhood can lead to heightened sensitivity in adults, thereby further increasing vulnerability to mental illness, even when precipitated later by 'seemingly minor events'. Moving from a discussion of depression to anxiety disorders, similar mechanisms may also be involved where HPA axis sensitivity is dysregulated by early life experience.

A recent paper on the social construction of anxiety disorders (Dowbiggin, 2009) reviews the sudden increase in prevalence of anxieties since the mid twentieth century. He examines the social factors linked to this new 'age of anxiety', describing 'a perfect storm of social, medical and biological circumstances [which] had converged to produce an upsurge in anxiety'. The use of the term 'stress', originally a physiological term in the 1930s, was widely adopted by the public to describe the problems of daily life and accompanying psychological distress. The rise of psychopharmacology and publicity around anti-anxiety medications and 'mood medicine' in the 1950s and 1960s came next, conveniently offering treatments for these complaints.

PTSD, which entered into the DSM in 1980, and its evolution in the USA after the Vietnam War, is used as a case example where 'reimbursement policies can heavily shape the destiny of a specific psychiatric diagnosis' (Dowbiggin, 2009). This diagnosis, originally developed for shell-shocked soldiers, largely men, returning to the USA, was then more widely adopted to describe victims of rape, domestic violence, child abuse and sexual assault, consisting largely, although not exclusively, of women. He cites Judith Herman, who wrote in 1992 that 'not until the women's liberation movement of the 1970s was it recognized that the most common post-traumatic disorders are not those of men in war but of women in civilian life' (Herman, 1992, in Dowbiggin, 2009). This coincided with the emergence of the self-help and recovery movement, with its accompanying 'culture of victimization' and medicalization of distress. The 1970s were also a time when women entered the workforce in large numbers. Dowbiggin, a historian, ends his review on rather a contentious note, ascribing current high rates of anxiety disorders found in women to the rise of the 'high-performing career supermom' fleeing into 'anxiety illnesses sanctioned by the wider cultural milieu', and comparing this to women's psychosomatic reactions of the nineteenth century with their related invalidism and hysteria.

In contrast, while exploring depression from a gender perspective using a qualitative methodology, it was found that Swedish men talked more easily about physical distress, most often the heart, while women verbalized more emotional distress, mainly shame and guilt, and when they did refer to physical symptoms it was mainly abdominal (Danielsson & Johansson, 2005). Women were also found to have a greater variety of words and metaphors to describe their mood than men. Both gender and socioeconomic class were found to influence the experience of depression.

In a further study of gendered trajectories into depression (Danielsson, Bengs, Lehti, Hammarstrom, & Johansson, 2009), four main routes to depression were identified through patient narratives of the explanatory models of their illness. While men most often reported being 'struck' by external circumstances, women had more diverse narratives, however, most commonly believing that depression came from internal factors such as their own personality or ways of handling life. Being able to pay attention to these different forms of expression could alleviate self-blame in women more focused on personal responsibility, shame and guilt, and also to improve recognition of depression in men: 'when treating depressed women and men, gender consciousness is required. Considering depressive symptoms as culturally dependent opens an array of possibilities to health care professionals. We may focus on gendered cognitive patterns in therapy, and make gendered societal attitudes visible, attitudes that are often left unquestioned. Women's tendency to self-blame and self-imposed responsibility for instance, might be identified and unburdened. Men, on the other hand, may need encouragement to express their emotions, establish close relationships, and accept responsibilities' (Danielsson et al., 2009). These findings are echoed on a larger scale in a review by Nolen-Hoeksema (2001), who recommends an integrative model that includes biological, psychosocial and cultural factors in working towards understanding gender differences in depression. Even the seemingly disparate worlds of neuroscience and cultural and psychological anthropology are coming together in studies that look at gender differences in emotional development, cultural expressions of emotion, and nascent areas of 'cultural neuroscience' using brain mapping and imaging techniques (Canli, Desmond, Zuo Zhao, & Gabrieli, 2002; Brody, 2006; Ambady & Bharucha, 2009).

Gender, mental illness and the body

Several of the papers cited above have alluded to effects of stress and distress, gender and the body and how they are differentially expressed and experienced by women and men. These differences will of course be filtered by a cultural lens as well.

In a study of healthy, white, middle-class women and men aged 35–55, Saltonstall (1993) advocates that the body 'must be considered in its concreteness as a lived experience of socially and historically situated men and women. This lived experience entails simultaneous processes of interpretation and communication: interpretation of one's own and other's particular bodies and communication of one's self as healthy and as a member of a social group. Gender is an underlying theme' (p. 7). Using

a qualitative approach, and simple open-ended questions such as 'do you consider yourself a healthy person?' and 'what do you do to keep healthy?', Saltonstall identifies significant gender differences in the ways that women and men view their bodies and their state of health, as well as their sense of self. He points out that contrary to the medical concept of the universal body that differs only according to reproductive capacity, in reality lay people's conceptions of their bodies are very different.

Another qualitative study focused on Russian women and men coping with stress and social transition (Pietila & Ryttonen, 2008) in a country with high rates of self-rated depression, anxiety, hopelessness and meaninglessness, suspected to be linked to the substantial social changes of living in a former communist state. In terms of gender differences, women were seen as stronger, more adaptable and more resilient than men whereas men were viewed as experiencing more stress because of their greater responsibilities in the workplace, as well as having a greater innate vulnerability to stress. It is notable that this view was shared by both female and male subjects. Another interesting finding was that the term 'stress' was used both to describe an individual psycho-physiological as well as the stressed state of society, and thus served the purpose of making sense of the impact of social transition on individuals, and helping with coping.

There is a very large body of literature on the socio-cultural context of women's body image being linked to eating disorders, obesity, physical and emotional health that is beyond the scope of this chapter. The influence of the mass media on women's self-confidence versus self-criticism has been widely studied. The prevailing norms of thinness in western society continue to affect women and girls in unhealthy ways (Orbach, 2009). Until recently, anorexia was thought to be a particularly western disorder, perhaps even considered a culture-bound syndrome of western Europe and North America (Tseng, 2003). A study on women's perceptions of body image issues in Canada (Paquette & Raine, 2004) found a complex relationship between the external forces in the media and women's internal perceptions which was fluid, dynamic and fluctuating, depending on the circumstances. They conclude that, in addition to the negative influence of unrealistic media images, 'partners, family, and friends – women's social networks – also perpetuate socio-cultural messages by supporting media's representation of social norms for acceptable bodies. By amplifying social pressure for women's bodies to be a certain way, women's relationships with others and with themselves reproduce a form of social control that enforces and reinforces an unrealistic and unhealthy social norm' (2004, p. 1056).

When taken out of the North American context, the influence of western media and Hollywood images continues to exert their power (Andermann, 2006). Perhaps the most striking example of this is the research of Anne Becker and colleagues (2002), who were in the fortunate position of being able to study eating disorders among adolescent girls in Fiji, just as television was being widely introduced, creating a natural laboratory. There had been no prior before and after studies looking specifically at the influence of the introduction of mass media on eating habits and body image. During the three-year follow-up, Becker's group found a significant increase in disordered eating following television exposure, and although there were no cases meeting full criteria for anorexia, self-induced vomiting to control weight had increased from 0% in 1995 to 11.3% only three years later (Becker, Burwell, & Gilman, 2002). There was also an increase in body dissatisfaction as girls wanted to appear more like characters on television. Most interestingly, this rapid change took place in a traditional Fijian setting that had previously valued a more robust body shape as the ideal, and had encouraged large appetites at feasts and family gatherings (Becker et al., 2002). Because of cultural differences, careful attention must be paid to create valid questionnaires that will not misinterpret culturally consistent responses. For example, in India, asking a question about 'engaging in dieting behaviour' could also mean observing Hindu religious fasts, while asking about 'cutting food into small pieces' in China would be appropriate food preparation for eating with chopsticks (Tseng, 2003).

Similar changes are happening around the globe. Ethan Watters devotes an entire chapter of his popular book on cultural psychiatry, *Crazy Like Us: The Globalization of the American Psyche* (Watters, 2010), to the rise of anorexia in Hong Kong. Through studies such as these, the introduction of western media imagery can be directly linked to the internalization of a new cultural ideal of thinness and the development of body dissatisfaction, leading in some cases to disordered eating.

Another broad research area involving gender and the body is around the experience of pain. Like body image, pain and its modes of expression also have wide cross-cultural and gender differences. Validity of symptoms can also be an issue that comes up against gender lines, as well as the dominant biomedical model. Werner and Malterud's (2003) exploration of chronic pain in women has shown the difficulties attached with being a 'credible patient' with a medically unexplained illness. Werner, Widding Isaksen, and Malterud (2004) also explore issues of self and shame in women with chronic pain,

and how patient narratives are shaped by cultural discourses of gender and disease.

In an earlier chapter, Andermann (2006) reviews the practice of female genital mutilation (FGM) and its physical and emotional effects, perhaps one of the most extreme examples involving control over women's bodies. There is an extensive literature about the potential risks of this practice to mental and physical health (Utz-Billing & Kentenich, 2008; WHO, 2008). However, because it is often mothers and older women who are responsible for the continuation of this practice, it is important to understand it in proper context. Anthropologist Janice Boddy has studied Somali society, a Muslim, male-dominated, pastoralist society, and described that although Islam does not sanction this practice, or gender-inequality in general, it is customary to view women as inferior to men, and concepts of honour, reputation, and independence are at the foundation of Somali social organization (Barnes & Boddy, 1995). Describing how women's sexuality keeps them in a socially inferior position, Boddy writes: 'Female fertility is highly prized; it is associated with plenty, prosperity, and life, with the continuation of the lineage through the birth of sons, and with the virtues of pity, mercy, and compassion. Nevertheless, women are considered socially less developed than men. They regularly and involuntarily menstruate; they give birth and lactate; when pregnant they publicly display their sexuality, their ties, that is, to other humans. All these natural conditions that women cannot control are seen to represent weakness and a lack of independence, the antithesis of the social ideal' (Barnes & Boddy, 1995, p. 318). With growing immigration, the issue of FGM has travelled to Europe and North America, where these values have to be re-negotiated with the hope of including these young women in a changing society (Desjarlais et al., 1995).

In its most concrete form, a focus on gender and the body can lead to a preference for male offspring in certain cultures (Andermann, 2006). Because of the importance of heredity and the maintenance of the male line in patrilineal societies, issues of inheritance and land ownership, and social rank, male children are often preferred. Financial stresses for the parents of girls in cultures that are required to produce a dowry constitute a heavy burden for families at the brink of poverty. The calculation by economist Amartya Sen of over 100 million 'missing women' worldwide is staggering, with female:male sex ratios of 92 women for every 100 men in India, and 87.9 women for every 100 men in China, and even 48 women to 100 men in United Arab Emirates are dramatic examples (Desjarlais et al., 1995). With new technologies that allow for simple screening for

the sex of the foetus, these choices become all too possible.

Going from a situation of structural violence to interpersonal violence, Ogden, Minton and Pain (2006) have highlighted the importance of focus on the body when treating trauma, through the use of a sensorimotor approach to psychotherapy. Echoing Bessel van der Kolk's (1994) view on trauma that 'the body keeps the score', the authors offer an adjunct to the 'talking cure', a treatment which addresses the impact of trauma on the body as much as the mind. While a more detailed discussion of the effects of psychological trauma and gender is not possible here, the effects of violence in women's lives continue to be all too prevalent and a major source of distress, and this is addressed by several of the other papers in this issue.

Migration, gender and mental health

Studies such as *Taking culture seriously: Ethnolinguistic community perspectives on mental health* (Simich, Maiter, & Ochocka, 2009) provide an excellent model for health research in multicultural, immigrant-receiving countries. Using focus groups with five ethnolinguistic groups in Ontario, Canada, the study was designed to understand culturally diverse conceptions of mental health problems, their perceptions of mental health interventions, and community perceptions about necessary services. Similar qualitative research methods could also be valuable in understanding mental health through the lens of gender by examining the changing roles of women and men immigrants and refugees, and their process of adaptation to their host country.

In a related publication, Simich et al. (2009) explore the concept of 'social liminality' among immigrants, and the stresses of being 'at the margins' or 'at the threshold' of society, and how this social exclusion can affect mental well-being. If mental illness is added to the equation, one can see how even further marginalization could be perpetuated, not only from mainstream society but also from the medical system. However, Simich et al. conclude on a positive note, noting that the concept of liminality implies the possibility of transformation, as in the anthropologist Victor Turner's concept of a rite of passage where one moves through different psychological states or roles in life.

Linking the study of migration to the earlier discussion on professional viewpoints, Barn (2008) examined British social worker conceptualizations of ethnicity, gender and mental health among migrant women from Bangladesh. He used semi-structured interviews with social work professionals in the UK to obtain their perceptions of Bangladeshi women's

mental illness, well-being, stress and use of mental health services. The study identified many relevant factors including poverty, poor and overcrowded housing, racism, language, culture, religion, and gender and patriarchy. There was generally a low use of social services by Bangladeshi women that likely did not reflect the true need in the community. Barn concludes that 'the experience of ethnicity is gendered and that gender relations are ethnically distinct and impacted by social class... understanding patriarchy and gender relations, as well as the wider context of race and ethnicity and the interconnections between ethnicity, gender and social class' is imperative in planning for meaningful and impactful mental health and social services (2008). On a much broader scale, the AESOP study (*Aetiology and Ethnicity in Schizophrenia and Other Psychoses*) has looked extensively at ethnicity, migration and mental health, as well as gender-related factors, in the UK with an emphasis on pathways to care (Morgan et al., 2006).

Looking at gender effects is not synonymous with women's health, although it often seems that way in the literature. The growing field of men's health is described as being 'in its nascence [and] has not yet compellingly represented the vulnerabilities of men and how men's jeopardies are not separate from, but are intertwined with, those of women and children. Doing so requires that we cast suspicious eyes upon simplistic notions of male privilege and male agency. These ideas can mislead, obscuring the reality of men's vulnerability and suffering' (Meryn & Young, 2010). The authors see a 'near-exclusive commitment' among governments, philanthropic organizations, and multi-national organizations to maternal and child health, and would like to broaden this effort to include men as well. Viewing poverty as one of the key social determinants of health leading to physiological and psychological diseases in the male gender, often of greater severity than in women, advocates for men's health and well-being are trying to improve representation and health services for groups of vulnerable men.

Much has been written about the need for focus on women as 'change agents' particularly in developing countries in Africa (Kalu, 1996). However, Kalu also emphasizes 'rearticulation of the male role within traditional thought' as a necessary and important step in solving these longstanding problems of inequality. In India, Davar (2008) traces the historical links between the engagement of the women's movement with mental health, disability and psychiatry over the past twenty years. The consequences of these developments with their associated terminology and political weight on the self-concept and identity construction of Indian women are explored. The paper is critical of medicalized, patriarchal and

globalized concepts of psychiatry, at the expense of more integrated, traditional healing models that take into account spirituality and mind–body connections.

Discussion

This review article presents a variety of studies from around the world looking at the social construction of gender at the intersection with mental health. While many important associations have been identified, further studies which take into account the interaction between biological and psychosocial factors are needed to explain the perpetuating factors in women's mental health, and more clearly address the problem of why simply identifying psychosocial factors in women's lives, and even taking steps to correct them, may not be enough to reduce rates of mental illness.

Some advances in maternal health are being made. A worldwide study of 181 countries reported in the *Lancet* that for the first time in decades, maternal deaths have dropped 35% from 1980 to 2008, from 526,000 to 342,900 (Hogan et al., 2010). They attributed this reduction to a number of factors including lower pregnancy rates, higher income, leading to improved nutrition and access to health care, more education for women, and greater numbers of skilled birth attendants assisting with labour and delivery. One can only imagine the mental health ramifications of such worldwide interventions, and it is interesting to imagine the psychological impact on both individual and societal levels. In fact, a Taiwanese study of over one million women has shown that parity confers a protective effect against suicide (Yang, 2010). Yang's research provides positive support for Durkheim's 1897 hypothesis that rates of death from suicide were lower in married women because of parenthood, rather than effects of marriage alone. The study also found a greater protective effect with increasing numbers of births, so that increasing parity was associated with decreasing suicide rates.

The *Lancet* study made headlines in the mainstream media because of a perceived 'conflict between science and advocacy' as women's health advocates tried to pressure the journal for a later release of these positive results, as they believed it could lead to a negative outcome at several important upcoming policy conferences, and that their support might be seen as a lesser priority if there was a perception (albeit erroneous) that the problem had already been solved (Grady, 2010). This clearly illustrates the point that where gender is concerned, issues of power and politics are never far behind.

Despite the overwhelming focus on the biomedical system in western psychiatric models, reviews of

research focusing on highly biological aspects of gender and sex differences in mental illness, including neurobiology, neurochemistry, sex steroids and endocrine sex reactivity, insist on attention to psychosocial aspects as well (Blehar, 2006; Vigod & Stewart, 2009). In their review of gene–environment interactions and impact on mental health, Vigod and Stewart write that 'emergent research highlights the impact of the interaction between genetics, hormones and life stress in a population disproportionately affected by depression and anxiety. This supports the importance of advocacy for the rights of women in that their mental health can only be improved with attention to the biological, psychological and sociocultural contexts' (2009). They recommend further study of gene–environment interactions across the lifespan, from childhood adversity to adult stress, in order to be able to develop better prevention and treatment, both psychological and pharmacological, for these conditions. Blehar (2006) describes developments in the field of women's mental health as a recognized field of biomedical research, while also emphasizing social and cultural factors as well as a public health perspective.

Identifying the psychosocial factors in women's lives linked to mental distress, and even starting to take steps to correct them, may not be enough to reduce rates of mental illness or improve well-being of women around the world. More studies which take into account the interaction between biological and psychosocial factors are needed to explore the perpetuating factors in women's mental health, and explain why these problems continue to persist over time and suggest strategies for change. And for these changes to occur, health system inadequacies related to gender must be addressed.

The intersection between culture, gender and mental illness must be considered at all levels within policy, research, and ultimately, front line services. Also, the benefits and tensions resulting from the creation of gender-specific services (women's clinics, women's programmes, etc.), and their impact on the mainstream mental health system need to be further studied. While there is no doubt that there are many examples from different countries of clinics and programmes open only to women that are providing excellent and much-needed services, advocacy and education, these usually exist only on a small scale. They are often difficult to sustain within larger programmes as their creation and continued existence may be too reliant on individual staff or personnel to keep them going. Ensuring ongoing funding remains an issue as this is often dependent on larger organizations that may have different priorities. The impact of these specialized clinics on developing the competence of the

larger health care organization or health system may also be limited.

Over a decade ago, Satel asked the controversial question: 'are women's health needs really special?', and expressed her opinion that this can lead to 'marginalization through specialization' (1998). In a similar vein, there has been a debate around the creation of ethno-specific services, which can often result in silos of specialized care for minority populations, rather than improving the cultural competence of mainstream services as a whole (Lo & Chung, 2005). While bringing gender-specific knowledge and expertise into the larger mental health care system with access to equitable and excellent care for everyone is the ultimate goal, at this time there still appears to be an important role to be played by specialized women's services (Burman, Chantler, & Batsleer, 2002; Kohen, 2001, Seeman & Cohen, 1998). For example, in their descriptive study of a mental health service for south Asian women in England, Burman et al. (2002) analyse 'the intersections between cultural, racialized, classed, and gendered positions in order to understand the conditions giving rise to these expressions of distress', and identify relevant policy challenges, issues and health practices. They argue that 'attending to the specific needs and conditions of south Asian women attempting suicide or self-harm by providing integrated culturally and gender-sensitive services highlights good practice for everyone' (p. 641). This study underscores the necessity of good clinical care also being culturally competent care, and vice versa.

As described throughout this paper, gender, politics and power relations are an important part of this health equation. In addition, much can be learned from qualitative studies of local social worlds, where ethnographic methods can illuminate individual experience and suffering, and provide the context necessary to look towards a healthier and more equitable future.

Conclusion

The social construction of gender has been shown to impact on health outcomes, and disparities, in the mental health status of women around the world. Research that addresses the role of culture as a determinant of mental health involving both qualitative and quantitative perspectives is essential in tackling these global issues.

The DSM-IV cultural formulation, particularly the components exploring cultural, family and gender identity, and power differentials in the relationship between patient and clinician, are useful tools for culturally competent clinical practice with a gender perspective.

The negative effects of social and gender inequalities on women's mental health outcomes have been clearly documented worldwide in many different socio-cultural settings, yet these situations persist. Health professionals must take women's local social realities into account when planning effective interventions.

Further study on the role of culture as a determinant of mental illness, as it intersects with gender, can begin to answer some important questions about issues of cultural relativity and universality in women's mental health.

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