Chapter 28

# Women and global mental health: vulnerability and empowerment

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## Introduction

This chapter takes an anthropological approach to the study of global mental health among women. We begin by framing our review broadly with the prolegomenon that "there is no health without mental health" (Prince *et al.* 2007). This declaration is welcome not only to researchers and clinicians dedicated to understanding mental illness but also to persons, families, and caregivers whose daily lives are much affected. Yet illness experience, cultural interpretation, and social response are not uniformly patterned. The realities of the social, cultural, and political dimensions of mental illness are not the same for women and men across diverse sociocultural settings. Research over the past three decades has empirically established the vital roles of culture and gender across a range of illness-related features such as etiology, vulnerability factors, illness onset, formation, social and occupational functioning, psychotherapeutic and medication experience, resilience, and course and outcome (Goldstein *et al.* 1989, McGlashan & Bardenstein 1990, Jenkins 2007, 2010).

These issues could hardly be of greater significance insofar as substantial bodies of research have demonstrated that gender and social response are significant for who becomes ill and who recovers (Jenkins & Karno 1992). A precise anthropological definition of global health is as:

> an area of research and practice that endeavours to link health, broadly conceived as a dynamic state that is an essential resource for life and well-being, to assemblages of global processes, recognizing that these assemblages are complex, diverse, temporally unstable, contingent, and often contested or resisted at different social scales.
>
> (Janes & Corbett 2010, pp. 406–7)

Taking up the challenge to integrate mental health into the global health agenda specific to women will require development of innovative programs of transnational research and intervention (Kermode *et al.* 2007, Alegria *et al.* 2008). In this chapter we explore the cultural, economic, and political determinants of women's mental health in an effort to identify directions for future research on pathways to improve women's well-being, emphasizing the role of empowerment.

In charting the course for a wide-ranging research agenda to expand the study of women's mental health, it is useful to bear in mind two impediments to such research in the form of paradigmatic bias within the health and social sciences. First is the enduring problem of dichotomous thinking about illness as "physical" or "mental," with the latter often non-existent or a secondary concern. The need for recognition of the tangible indivisibility of mental and physical illness holds particular relevance for women's mental health. Consider, for example, mental and infectious diseases. Research shows that regardless of race or ethnicity, HIV-positive women have more severe histories of abuse than do women who are HIV-negative (Wyatt *et al.* 2002). The significant risk for HIV among women with histories of physical and sexual abuse is related to the mental health risks of adverse social conditions, such as depression, psychological trauma, and psychosis (Breslau *et al.* 1997, Tolin & Foa 2006, Fisher *et al.* 2009). For instance, when girls and women who have been abused become depressed or traumatized, they may not feel motivated or entitled to insist on condom use that would reduce their risk of infection (Abt 2008). Such a situation illustrates not only the interrelation of infectious disease and mental illness but also the nexus of gender and power as a social determinant of illness.

*Essentials of Global Mental Health*, ed. Samuel O. Okpaku. Published by Cambridge University Press. 

Second, it is only within the last two decades that women have not been largely excluded from research protocols, based in part upon the presumption that disease processes among women are similar to those among men, typically European or North American men. Empirical studies have shown otherwise. There are distinctive features of illness among women that do not apply to men (Jenkins & Schumacher 1999, Nasser *et al.* 2002). For example, meta-analyses by Tolin and Foa (2006) demonstrate a significant relationship between child abuse and post-traumatic stress disorder (PTSD) for females but not for males. For psychotic-related disorders, childhood sexual and/or physical abuse is a major risk factor in the onset of psychosis for women, but not for men (Fisher *et al.* 2009). Symptoms of PTSD as developed by the DSM-IV for male American war veterans do not fully apply to Central American women who have experienced warfare and political violence (Jenkins 1996).

Taken together, these observations point to the need for research that takes into account features of culture and gender for investigation of women's mental health in a globalizing world. As an initial step toward this objective, we turn first to epidemiological data regarding the prevalence and economic burden of mental illness worldwide.

## Epidemiology

In an extensive report on *The Global Burden of Disease*, the World Health Organization (WHO) has compared calculations for the total number of years of potential life lost due to premature mortality and the years of productive life lost to disability (disability-adjusted life years: DALYs). Globally, neuropsychiatric disorders among non-communicable diseases rank number one in global burden of disease (Figure 28.1). This is especially striking considering that non-communicable diseases account for nearly half of the global burden of disease (Figure 28.2). However, as Table 28.1 shows, there is some cross-national and gendered variation. For men and women in the six most populous countries (USA, Japan, China, Indonesia, Brazil, and India) as well as in Pakistan and Iran, neuropsychiatric disorders have the highest burden among non-communicable diseases, followed by cardiovascular illness. In Afghanistan, both men and women have a greater cardiovascular disease burden, followed by neuropsychiatric illness, and in Turkey, Iraq, and Saudi Arabia this pattern only holds for men (World Health Organization 2008). Considering the dramatic burden caused by neuropsychiatric illness, it is all the more

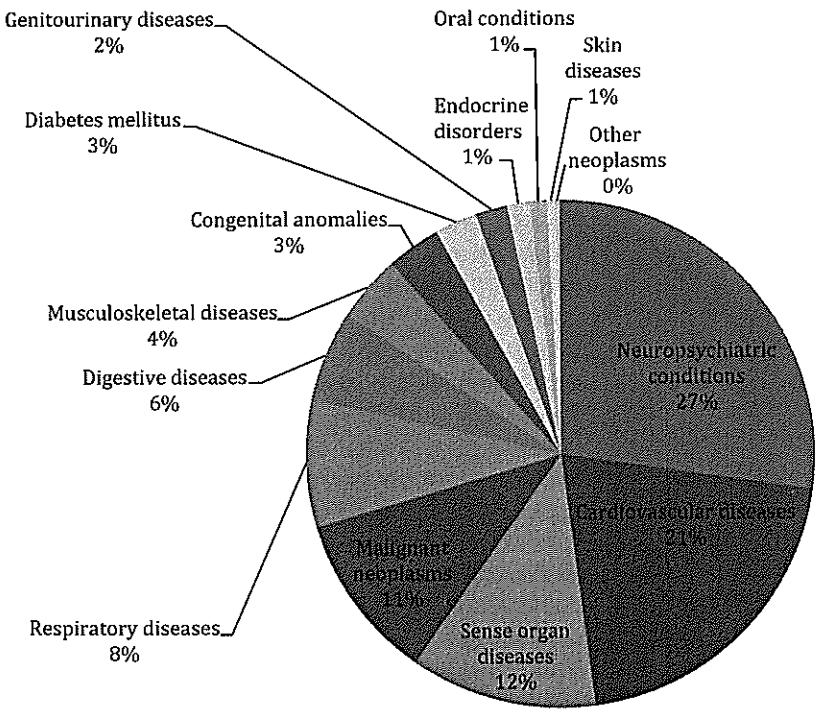



**Figure 28.1** Distribution of global DALYs among non-communicable conditions. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

**Table 28.1** Leading sources of DALYs among non-communicable disease in selected countries

| | Men | | Women | |
|---|---|---|---|---|
| | Neuropsychiatric conditions | Cardiovascular conditions | Neuropsychiatric conditions | Cardiovascular conditions |
| | Rank | Rank | Rank | Rank |
| USA | 1 | 2 | 1 | 2 |
| Japan | 1 | 2 | 1 | 2 |
| China | 1 | 2 | 1 | 2 |
| Indonesia | 1 | 2 | 1 | 2 |
| Brazil | 1 | 2 | 1 | 2 |
| India | 1 | 2 | 1 | 2 |
| Pakistan | 1 | 2 | 1 | 2 |
| Iran | 1 | 2 | 1 | 2 |
| Afghanistan | 2 | 1 | 2 | 1 |
| Turkey | 2 | 1 | 1 | 2 |
| Iraq | 2 | 1 | 1 | 2 |
| Saudi Arabia | 2 | 1 | 1 | 2 |

*Source:* Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

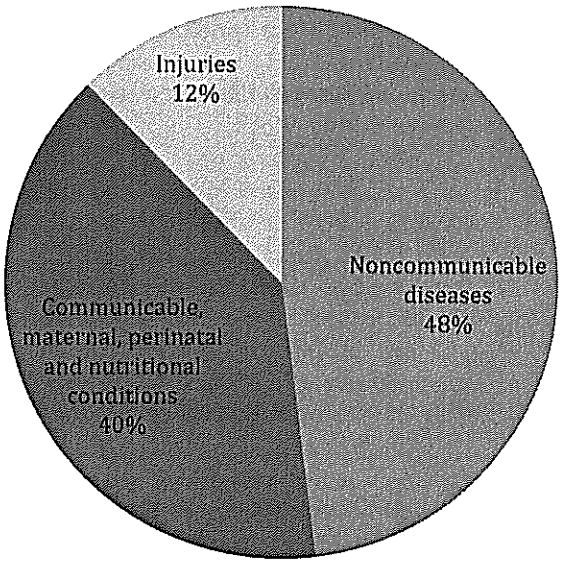



**Figure 28.2** Distribution of global DALYs by type of condition. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

remarkable that mental health care receives such low priority in global health. In many countries, there is scant attention from policy makers and little funding allocated to provide basic care.

For this chapter, we elaborate upon the WHO analyses, utilizing the 2009 updates on the DALYS and global burden of disease to consider comparisons between women and men in the context of selected countries (World Health Organization 2008, 2009). We present global trends as well as a comparison across the world's five most populous countries (China, India, USA, Indonesia, Brazil) and six quite diverse predominantly Muslim countries of high, medium, and low income, three of which have been highly affected by war (Turkey, Saudi Arabia, Iran, Iraq, Pakistan, and Afghanistan).

In agreement with decades of research on gender differences in the rate of depression (Good & Ware 1995), the WHO reported that "the burden of depression is 50% higher for females than for males," and that "the burden of alcohol and drug use disorders is nearly seven times higher" for males than for females in all countries, even if categorized by low, middle, and high income (World Health Organization 2008; p. 36), as illustrated by Figure 28.3.

Women's mental health across the lifespan is characterized not only by a higher burden of depression, but also by higher prevalence of anxiety

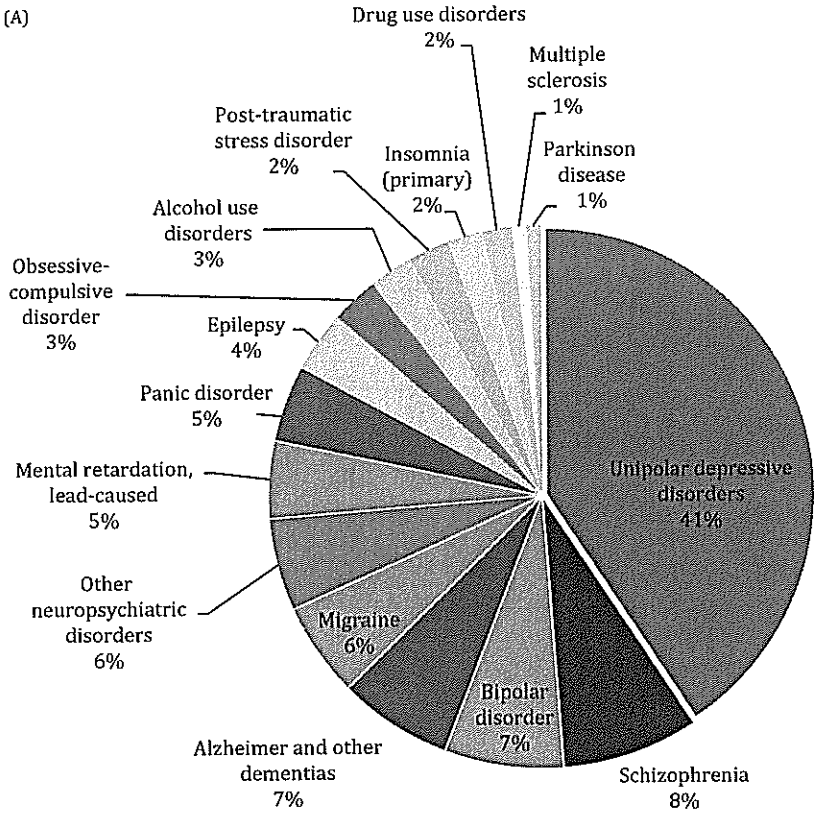



**Figure 28.3** Distribution of global DALYs due to neuropsychiatric conditions: (A) women; (B) men. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

disorders, and, given greater longevity, dementias (World Health Organization 2008; p. 36). The gendered experience of neuropsychiatric disorders is born out by the number of DALYs experienced by men and women across the globe. Figure 28.4 documents gender differences by country for the burden of unipolar depression, with women consistently showing higher DALYs than men, with the exception of Iran. Although women have a greater burden of disease across all countries from unipolar depression, the six Middle Eastern countries have a higher percentage of DALY burden from unipolar depression than the six largest countries, including Indonesia, also a Muslim-majority country.

Figure 28.5 illustrates the burden of alcohol and drug abuse for each of the six countries. Men suffer more disability from alcoholism or drug use, in contrast to women, who suffer depression. Cross-national variations are notable, with Japan, Turkey, and Saudi Arabia showing men with the least burden of either alcohol or drug dependence.

In contrast to depression and alcohol and drug disorders, there are few gender differences in the burden of bipolar disorder and schizophrenia across the 12 countries we examined. Figure 28.6 shows little difference in the DALYS per 100 000 population between males and females, yet differences are notable across the selected countries, with USA and Japan standing out with much lower burdens. One might ask, is this notable difference due to lack of effective treatment coverage?

Based on a comparison of data from Middle Eastern countries with the statistics for the six largest countries, one might hypothesize that the gender gap for depression is likely to be lower in countries with state ideologies that value and invest in women's health and promote female education to achieve equality and parity with men. However, the diverse sources of DALYs due to neuropsychiatric conditions make it difficult to evaluate this claim. As Figure 28.7 shows, while there is a consistent gender gap across all 12 countries in neuropsychiatric disorders, in China, Turkey, Iraq, and Afghanistan it is actually men who suffer a greater burden than women. What is more, the size of the gender gap is not larger in the Muslim countries than in the

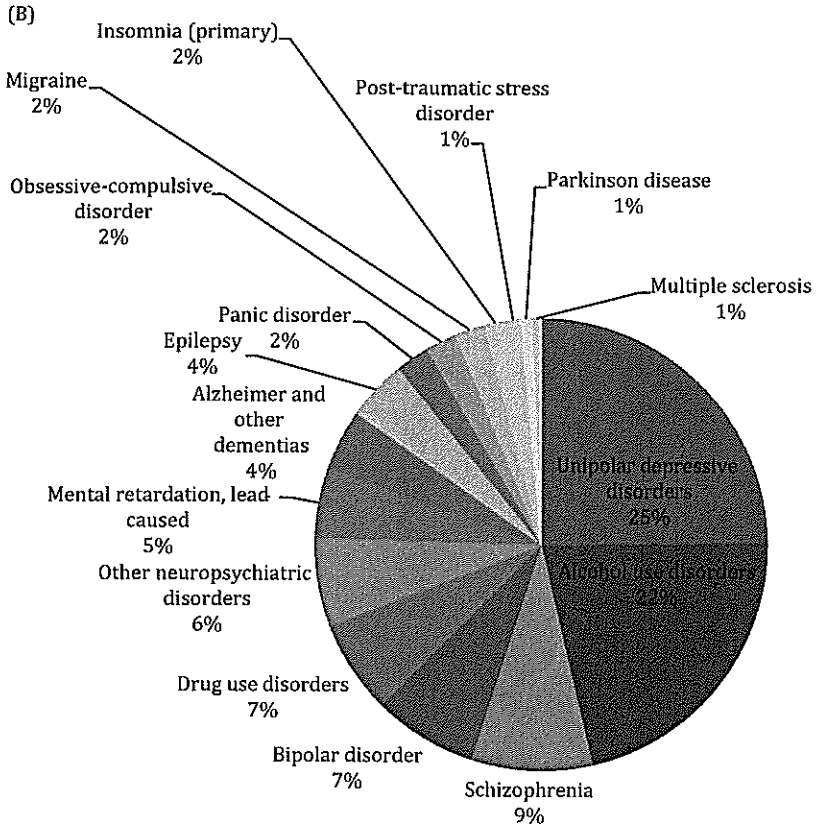


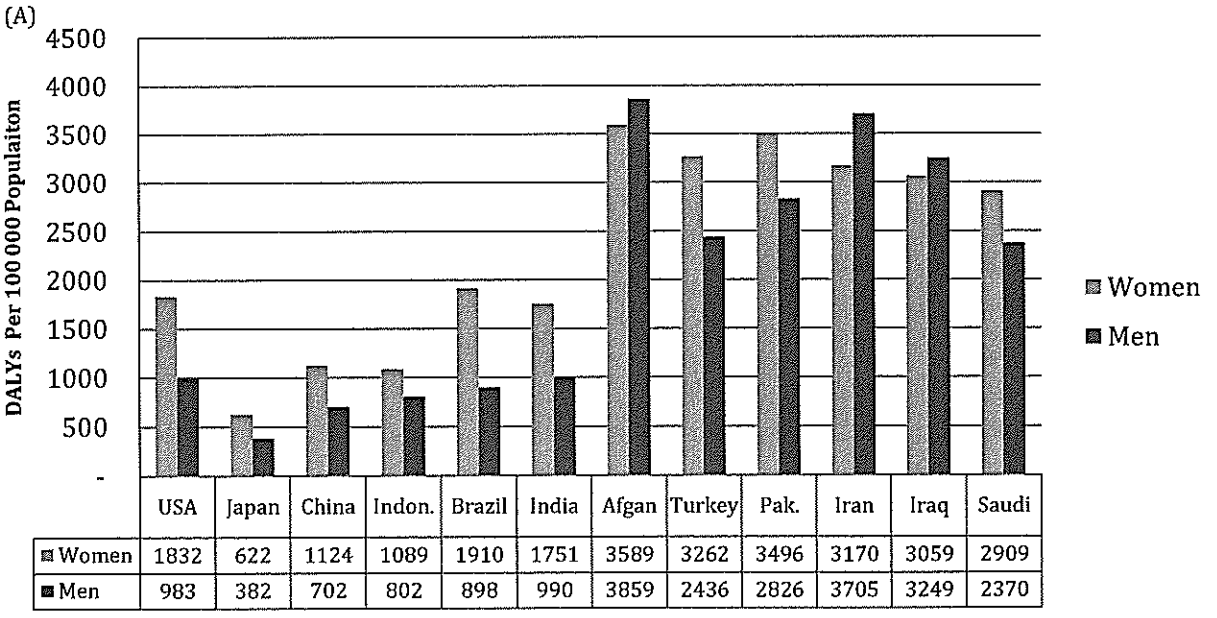

**Figure 28.3** *(cont.)*

non-Muslim countries. Despite these inconsistent findings, when examining individual neuropsychiatric disorders as we do here, interesting gender differences do emerge. As shown in Figure 28.4a, there is substantial gendered variation across countries, with Muslim countries suffering greater depression burden than non-Muslim countries and with women in Muslim countries suffering from a greater gender gap in depression burden than women in non-Muslim countries. Additionally, as shown in Figure 28.5a, the gendered pattern of alcohol and drug use disorder implicates state-level policy differences regarding the availability of drugs and alcohol, with women's access to these substances severely restricted in some countries, and more general availability in others. This raises the possibility that in countries where drugs and alcohol are less available, as in the many Muslim countries, depression levels may be elevated due to the inability to "self-medicate" with other substances. As Figure 28.4a shows, depression is highest in countries where alcohol abuse is the lowest.

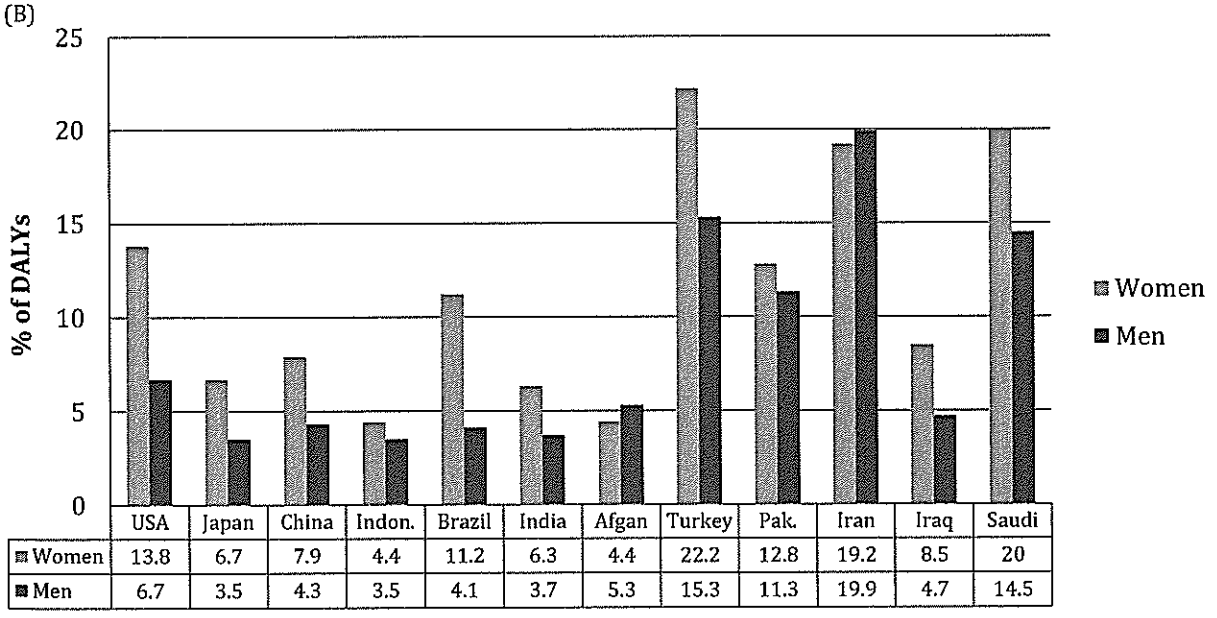
Another potential factor driving the gendered burden of neuropsychiatric illness across countries is the experience of violence and war. Table 28.2 illustrates the burden of disease from intentional injuries (self-inflicted injuries/suicides, war and violence). Afghanistan, Iraq, and Pakistan have suffered disproportionately from the burden of war, which has particularly impacted the men in those countries. Although war, violence, murder, and suicide affect low percentages of a population, insecure societies are highly related to mental distress and illness.

## Anthropological concepts as foundation

Because we are convinced that meaningful appreciation of these epidemiological data is usefully guided by enriching the theoretical models from which we work, we briefly review anthropological concepts that we believe can refine and guide research on mental health and illness among women. While there have been important strides in obtaining



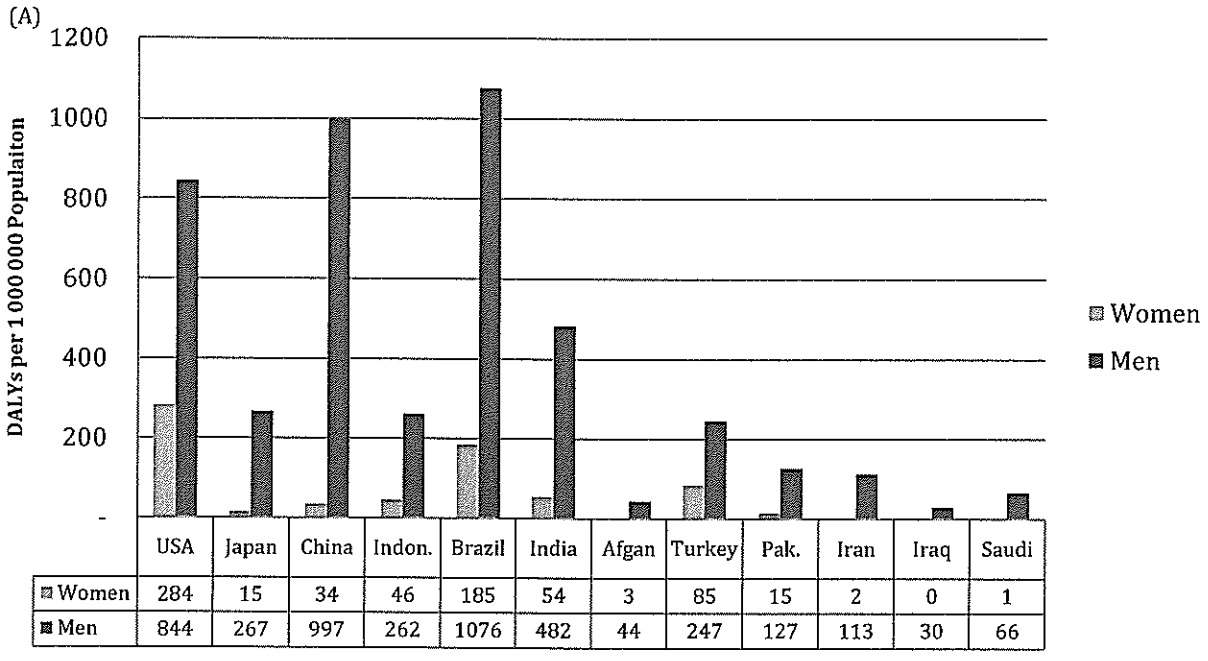

| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 1832 | 622 | 1124 | 1089 | 1910 | 1751 | 3589 | 3262 | 3496 | 3170 | 3059 | 2909 |
| Men | 983 | 382 | 702 | 802 | 898 | 990 | 3859 | 2436 | 2826 | 3705 | 3249 | 2370 |



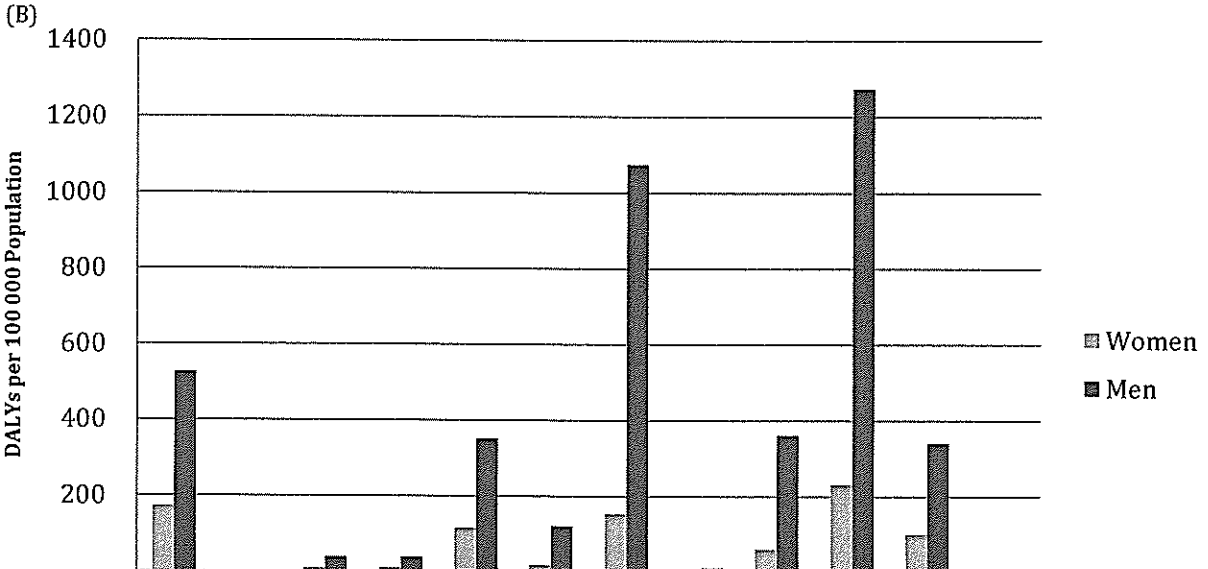

| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 13.8 | 6.7 | 7.9 | 4.4 | 11.2 | 6.3 | 4.4 | 22.2 | 12.8 | 19.2 | 8.5 | 20 |
| Men | 6.7 | 3.5 | 4.3 | 3.5 | 4.1 | 3.7 | 5.3 | 15.3 | 11.3 | 19.9 | 4.7 | 14.5 |

**Figure 28.4** Distribution by gender of DALYs due to unipolar depressive disorders in selected countries: (A) DALYs per 100 000 population; (B) DALYs due to unipolar depressive disorders as a percentage of DALYs due to non-communicable disease. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

fundamental empirical data for this burgeoning field, there is a critical need for well-formulated theoretical frameworks that can advance our understandings of cultural, social, and political processes that affect health and illness. To that end, we provide brief discussion of three central organizing concepts that can guide research: culture, gender, and power.

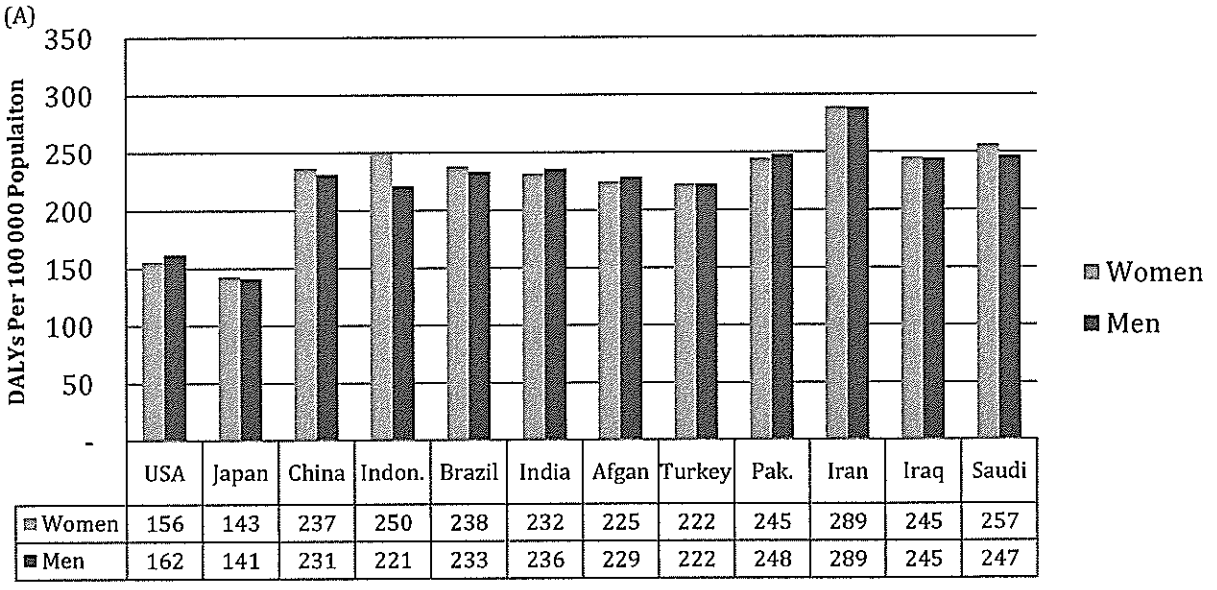



| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 284 | 15 | 34 | 46 | 185 | 54 | 3 | 85 | 15 | 2 | 0 | 1 |
| Men | 844 | 267 | 997 | 262 | 1076 | 482 | 44 | 247 | 127 | 113 | 30 | 66 |

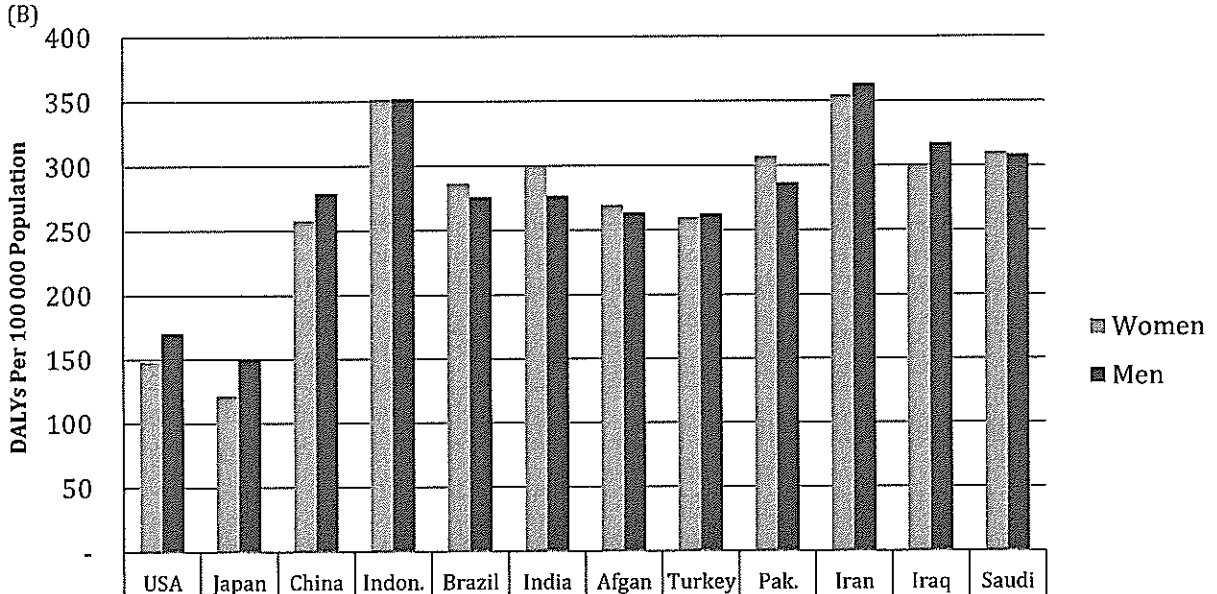



| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 173 | 1 | 11 | 11 | 117 | 21 | 154 | 4 | 63 | 232 | 102 | 2 |
| Men | 526 | 2 | 41 | 41 | 351 | 122 | 1075 | 13 | 362 | 1274 | 342 | 11 |

**Figure 28.5** Distribution by gender of DALYs due to (A) alcohol disorders and (B) drug disorders, in selected countries. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.




| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 156 | 143 | 237 | 250 | 238 | 232 | 225 | 222 | 245 | 289 | 245 | 257 |
| Men | 162 | 141 | 231 | 221 | 233 | 236 | 229 | 222 | 248 | 289 | 245 | 247 |




| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 148 | 122 | 258 | 352 | 287 | 300 | 270 | 260 | 307 | 355 | 299 | 310 |
| Men | 171 | 150 | 279 | 352 | 276 | 277 | 264 | 263 | 287 | 363 | 317 | 308 |

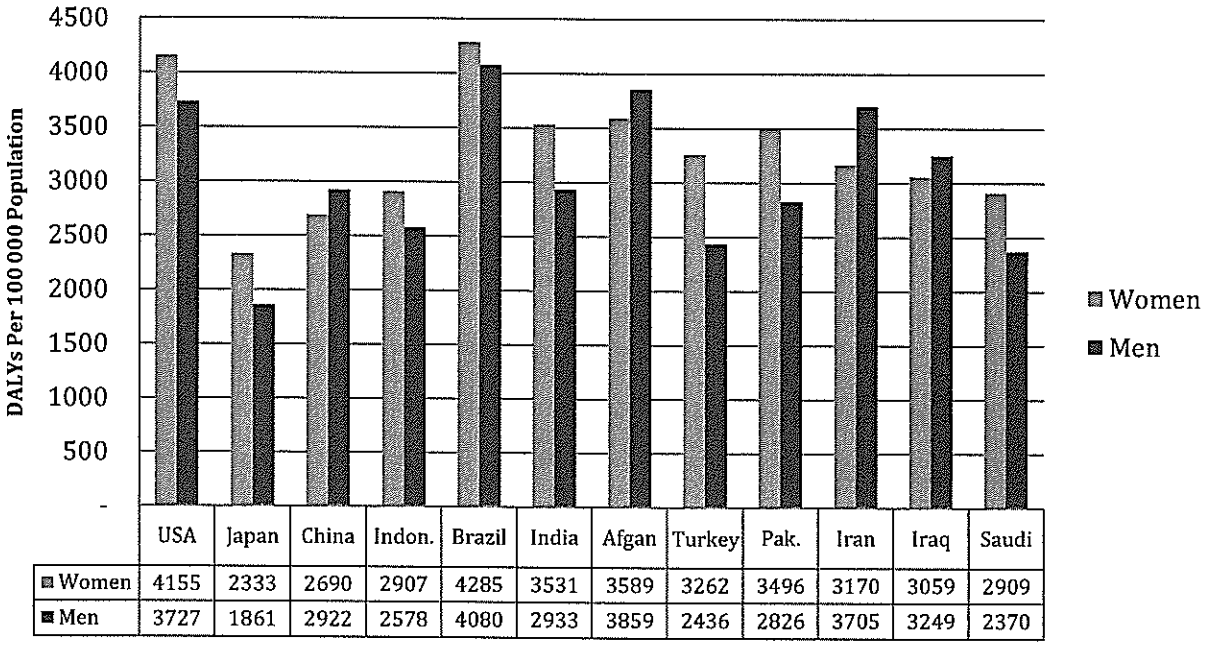
**Figure 28.6** Distribution by gender of DALYs due to (A) bipolar disorder and (B) schizophrenia, in selected countries. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

Culture can be conceptualized as an emergent property of context-bound human interaction, and cannot be operationalized as a variable. In its broadest dimensions, "culture can be conceived as shared symbols and meanings that people create and recreate in the process of social interaction. Culture shapes experience, interpretation, and action. It thereby orients people in their ways of feeling, thinking, and

**Table 28.2** The distribution of DALYs due to intentional injuries: suicide, violence, and war. Selected countries, per 100 000 population

| | Total for all categories | | Self-inflicted injuries | | Violence | | War | |
|---|---|---|---|---|---|---|---|---|
| | M | F | M | F | M | F | M | F |
| Afghanistan | 21.5 | 12.2 | 3.9 | 8.8 | 5.6 | 0.9 | 10.6 | 2.2 |
| Brazil | 66.8 | 7.4 | 8.5 | 2.3 | 57.7 | 5.1 | – | – |
| China | 18.3 | 20.3 | 15.1 | 18.9 | 2.9 | 1.3 | – | – |
| India | 28.7 | 17.4 | 20.2 | 13.3 | 7.1 | 3.8 | 0.8 | 0.1 |
| Indonesia | 29.4 | 13.1 | 12.4 | 9.1 | 14.4 | 3.6 | 2.2 | 0.3 |
| Iran | 11.3 | 6.6 | 6.7 | 5.5 | 3.9 | 1.1 | – | – |
| Iraq | 404.5 | 46.6 | 22.8 | 7.6 | 13.1 | 1.5 | 364.2 | 37.4 |
| Japan | 37.4 | 13.9 | 36.8 | 13.4 | 0.6 | 0.5 | – | – |
| Pakistan | 19.6 | 15.1 | 9.6 | 11.1 | 4.0 | 3.1 | 5.7 | 0.8 |
| Saudi Arabia | 16.0 | 4.0 | 10.1 | 1.6 | 4.2 | 2.0 | 1.0 | 0.2 |
| Turkey | 9.2 | 3.9 | 4.4 | 2.9 | 4.8 | 1.0 | – | – |
| USA | 28.1 | 7.4 | 17.8 | 4.8 | 9.4 | 2.6 | 0.6 | 0.0 |

*Source:* Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.




| | USA | Japan | China | Indon. | Brazil | India | Afgan | Turkey | Pak. | Iran | Iraq | Saudi |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Women | 4155 | 2333 | 2690 | 2907 | 4285 | 3531 | 3589 | 3262 | 3496 | 3170 | 3059 | 2909 |
| Men | 3727 | 1861 | 2922 | 2578 | 4080 | 2933 | 3859 | 2436 | 2826 | 3705 | 3249 | 2370 |

**Figure 28.7** Distribution by gender of DALYs due to neuropsychiatric disorders in selected countries. Source: Mortality and Burden of Disease Estimates for WHO Member States in 2004. February 2009 Update. Compiled by Seth Hannah.

being in the world" (Jenkins & Barrett 2004, p. 5). Fully understood, culture affects all aspects of mental illness. Traditionally, there have been two anthropological directions from which to understand culture: from multiple perspectives of actors who are the subject of study (*emic perspective*) and from conceptual and analytic perspectives of the anthropologist (*etic perspective*). The value of the latter is contingent on the validity and depth of understanding of the former.

Mental health and illness cannot be adequately understood without specific attention to sex and gender (Lewine 2004, Keyes & Goodman 2006, Chandra & Satyanarayana 2010, Kohen 2010). Typically in the health sciences the term *gender* is used when what is really under discussion is a dichotomous distinction of biological sex assignment of women or men. Gender, however, is a construct better conceived on a continuum as diverse assemblies of masculine and feminine cultural orientations. As a dimension of culture, gender pervades social life and experience (Rosaldo & Lamphere 1974, Rosaldo 1980). This cultural pervasion notably includes illness experience (Jenkins 2004), with gender role and identity as domains of particular relevance (Nasser *et al.* 2002). What is critical in the arena of health is the identification not only of gender difference but also of inequity. Comparatively, there are significant differences in preferences and moral injunctions for what women and men can or cannot do. Fairly consistent across cultures is a distinct difference between women's and men's access to economic resources and decision-making authority. Analysis of the cross-cultural record led Rosaldo (1980) to comment as follows on male dominance in these areas:

> Male dominance, in short, does not inhere in any isolated and measurable set of omnipresent facts. Rather, it seems to be an aspect of the organization of collective life, a patterning of expectations and beliefs which gives rise to imbalance in the ways people interpret, evaluate, and respond to particular forms of male and female action. We see it not in physical constraints on things that men or women can or cannot do but, rather, in the ways they think about their lives, the kinds of opportunities they enjoy, and in their ways of making claims.
>
> (Rosaldo 1980, p. 394)

However, as noted by Scheper-Hughes (1983, p. 30), "this 'gendering' of social life is situational and contextual, not meaningful in all spheres of behavior and activity, and variable, too, throughout the life cycle." There is no absolute fixity of female subordination, and indeed there is considerable social and cultural movement across place and over time. As Ortner (2006, p. 7) has argued, it is important to recognize that "male dominance always coexists with other patterns of gender relations; what is important is the mix, and the relations between them."

Sociocultural definitions of power take into account the relationship between institutional and structural arrangements and the agency of persons living under such arrangements. The cultural process of shaping varies not only in relation to broad dimensions of subjectivity but also in relation to historic regimes of power. While it is essential to conceive this relationship as an active process that is subject to dynamic change, the construction of individual and collective agency directed toward social change is contingent on access to vital economic and educational resources largely controlled by elites, the state, and other governmental and non-governmental organizations. Drawing on practice theorists such as Bourdieu, Ortner (2006, pp. 6–9) frames the question of power in relation to the extent of pervasiveness and invasiveness, internal dynamics (local relations) and external forces (such as capitalism and colonialism) over time. In this view, it is necessary to conceive of power as structures external to individuals and as lived social process that can be modified, resisted, and challenged. From this perspective, there exists a broad spectrum of the psychological "depth" of power as deeply internalized or resisted (Ortner 2006).

## Women and depression: gender vulnerability

Because depression looms large for women and girls and the condition is common across populations, we examine this illness in relation to factors of vulnerability. To expand upon the epidemiological data we presented above, there now exists a great volume of research demonstrating that depression affects women at a rate at least twice that of men, posing the question of how to account for this variance. Investigation has been carried out concluding that the etiology of depression among girls and women is multidimensional, to include biological, psychological, economic, and social factors (Nolen-Hoeksema *et al.* 1999). The classic work by Brown and Harris (1978) demonstrated the significance of a

constellation of factors that shape the lives of working-class London women: unemployment, poor housing conditions, three or more small children in the house, loss of mother before the age of 11, and the lack of a confiding relationship. The etiological significance of these interlocking conditions may point to thinking about depression in this case as a diagnosis of a situation rather than of an individual woman.

Another situational factor for the development of depression among women is workload. Abbott and Klein (1979) have identified depression among rural Kenyan women who have increased workload in the context of patrilineal determination of property rights and migratory flight of husbands seeking employment. The presence of strain in a domestic environment characterized by scarcity of economic resources, male dominance, overwhelming workload, familial demands in the absence of support, along with a tendency for ruminative worry and perceived lack of control or mastery over the conditions of one's life, are strongly correlated with depression in women (Ullrich 1987, Scheper-Hughes 1993, Nolen-Hoeksema *et al.* 1999). Taken together, the body of empirical research on depression suggests that depression among women can be conceived less as a psychological or individual ailment but more broadly as a diagnosis of the social situation, not only among working-class women in London but for many women the world over. This is not to deny or minimize the experience of intense distress and personal pain that defines depression in a woman's life, but rather to emphasize the structural conditions under which depression is produced. The intractability of these conditions parallels the severity of the disorder insofar as "depression appears to affect women more seriously than men, as manifested by an earlier age of onset, greater family history of affective disorders, greater symptom reporting, poorer social adjustment and poorer quality of life" (Kornstein *et al.* 2000, p. 1).

Review of a particular case study provides illustration. In a classic work entitled *Search for Security: an Ethno-Psychiatric Study of Rural Ghana* (Field 1960), anthropologist–psychiatrist M. J. Field provides the basis for comparing recent historical and contemporary conditions among women. Field found depression to be common among women. Locally the problem is conceived as witchcraft, for which "nearly all such patients come to the [healing] shrines with spontaneous self-accusations of witchcraft – that is, of having caused harm without concrete act or conscious will." A woman "is taken at her word when she says she has done harm" (Field 1960, p. 149). For example, one woman conveyed that she knew she was "no good and had become a witch. I have done so much evil that I ought to be killed" (Field 1960, p. 150). Among middle-aged and elderly women, Field observed depression with agitation to be "one of the commonest and most clearly defined of mental illnesses." The majority of these women spent their lives laboring to provide income for children's schooling through trading, market gardening, or cocoa farming (Field 1960, p. 149).

As common as these women's misery and self-accusations of witchcraft is their experience of "seeing their husband take on an extra and younger wife so that he may continue to beget children" and in so doing allocating funds for the young woman that are "the fruits of his older wife's years of labor" (Field 1960, p. 152). The cultural value of middle-aged women and their right to economic and psychological well-being is undermined by the gendered inequality of male social privilege and opportunity.

To bring the issue into more contemporary focus, the problem has worsened dramatically as older women suspected of witchcraft are not infrequently assaulted and sometimes killed (Adinkrah 2004). In Ghana, witchcraft-related femicide is rooted in "patriarchal attitudes, misogynistic beliefs, and ageist values [that] mediate witch beliefs in Akan society" (Adinkrah 2004, p. 335). At risk are poor and elderly women with little formal education who may be "threatened, drugged, beaten, forced to submit to humiliating ordeals, or coerced into confessing to imaginary witch activities" (p. 337). In certain cases, the accused are abandoned by their families and communities and banished to remote camps with threats of violence should they return. The camps are abject sites for the containment of witches (predominantly women) and the mentally ill (Van Dijk 1997, Palmer 2010). Only recently has there been political will to abolish these camps through meetings of civil leaders and the chief psychiatrist of Ghana's Health Services, who has argued for public awareness of psychological disorders and behavior associated with witchcraft.

As we have seen above, depression takes root in the lives of girls and women living under conditions of social adversity and cultural degradation. As also noted, psychotic-related illnesses, eating disorders,

and PTSD are more likely to develop in females than in males after exposure to sexual, physical, or psychological assault. Gendered dimensions of the illness are likely multifactorial, and include biological as well as psychological and sociocultural processes (Bird & Rieker 1999). Nevertheless, the overall vulnerability of girls and women to mental illness must be accounted for in part by women's greater likelihood of occupying socially subordinate status and being subject to unequal power relations. This state of affairs has sparked governmental and non-governmental agencies to undertake an array of initiatives under the banner of female "empowerment," to which we now turn.

## Empowerment

Bearing in mind the above sociocultural conceptualization of power as a relationship between institutional and structural arrangements and the agency of persons living under such social arrangements, we turn now to what currently has become a global movement. Since the 1980s there has been an ever-increasing attention to the global reach of the notion of women's "empowerment" as central to development programs. The UN Program on Population and Development and Inter-Agency Task Force has advanced "guidelines on women's empowerment" (United Nations 2001), defining the concept as follows:

> Women's empowerment has five components: women's sense of self-worth; their right to have and to determine choices; their right to have access to opportunities and resources; their right to have the power to control their own lives both within and outside the home; and their ability to influence the direction of social change to create a more just social and economic order, nationally and internationally.

In this formulation, it is critical to conceive of the notion of empowerment in culturally substantive terms. This applies with equal force to projects intended to foster empowerment. These must be generated in light of local preferences and priorities. The extent to which the numerous governmental and non-governmental agencies dedicated to the task of empowerment of women are likely to succeed is directly proportional to the extent to which the implementation of programs is carried out in partnerships that contribute to infrastructure that local residents regard as useful.

Of interest for mental health in relation to the UN definition of empowerment is the explicit concern for cultural and psychological "self-worth." Anthropologists have established cultural and gender differences in the orientation of the self (e.g., egocentric or sociocentric) that while not entirely different from European or North American selves may nonetheless differ in non-trivial ways (Shweder & Bourne 1984). With this in mind, the task force set up by the UN has usefully moved beyond a prior emphasis on reproductive health and toward health understood as "complete physical, mental, and social well-being." Actions and attitudes that can improve self-regard, countering institutional misogyny, sexism, and violence against women, are sorely needed. We emphasize that these need to be pursued in socially and culturally meaningful ways that are non-hegemonic.

Another recent document that targets the empowerment of women was produced by the World Psychiatry Association (WPA) (Stewart 2006). As for the UN Task Force, the focus on the improvement of women's mental health is grounded in the discourse of human rights and equal access to employment, health care, adequate food, water, and shelter. The WPA has also called for the "elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation, or religious beliefs" (Stewart 2006, p. 62).

Challenges to the implementation of principles designed by organizations dedicated to the empowerment of women are daunting, given widespread and longstanding conditions for women. Principal among these are sexism and poverty. Sexism, defined as institutional and cultural devaluation of girls and women, runs the gamut from legal codification to subtle and near-invisible hostility and constraint on the lives of women. Sexism as cultural devaluation is evident in poor countries through the denial of educational opportunities to girls, and in more affluent countries in the form of unequal pay and representation in the political arena. Sexism as hostility is evident in the harassment and sexual assault of women, for example among the small contingent of Afghan women carrying out their duties as policewomen (Gutcher 2011) or among American female troops sexually assaulted by their fellow soldiers (Myers 2009). Institutional sexism leading to a preference for males in Asia prompted Amartya Sen (1990) to famously inquire about the more than 100 million girls who are "missing" as evidence of abnormal sex ratios in India, China, and elsewhere in the developing world. While many factors account for this disparity, perhaps

the most notable is what has been termed "gendercide" (Economist 2010a, 2010b), whether through selective abortion, infanticide, or neglect (Scheper-Hughes 1993).

From a global perspective, the mental health of women is greatly affected by poverty, violence, and scarcity of basic resources such as food and water (Scheper-Hughes 1993, Desjarlais *et al.* 1995, Das *et al.* 2000, Farmer 2004, Janes & Corbett 2010). In a review of studies in low- and middle-income communities, however, Patel and Kleinman (2003) found that while most studies showed an association between indicators of poverty and the risk of mental disorder, the most consistent association was with low levels of education, with lesser evidence to support a specific correlation with income levels. Instead, "factors such as the experience of insecurity and hopelessness, rapid social change and the risks of violence and physical ill-health may explain the greater vulnerability of the poor to common mental disorders" (Patel & Kleinman 2003, p. 609). Low income was noted to have direct and indirect costs associated with mental illness through exacerbation of adverse economic conditions that create a vicious cycle of poverty and mental disorder.

In the face of these conditions, it is important to identify sources of strength and resilience displayed by women under such circumstances (Jenkins 1996, Scheper-Hughes 2008). Women are adept at maintaining relations that are strategic for emotional support and social capital (Almedom 2005). In times of crisis or warfare, women often intensify their labor and go to great lengths to protect their kin and community (Jenkins 1996). Currently, there is a pressing need for better understanding of the qualities and conditions of resilience among women. In this chapter, we feel the most compelling way to explore this is through presentation of a case study of women exercising power to safeguard the security of families and community under siege.

## Mental health in a post-conflict zone: women as protectors in Aceh

The following is an ethnographic example of women in the position of powerful protectors in post-conflict Aceh, Indonesia. This provides an example of the impact of localized armed conflict on women's mental health, exemplified by a generational conflict between the national military of Indonesia and the Free Aceh Movement (GAM) seeking provincial autonomy and ultimately independence. Following the Indian Ocean tsunami of December 25, 2004, a lasting peace in August 2005 granted local political autonomy and greater control over the province's wealth (Good 2010). Women and men described sustained violence by the military in their

**Box 28.1: Case study 1**

In July 2008 I reviewed the work of the International Organization for Migration (IOM) medical mental health outreach team. Villagers praised the IOM clinicians, and stories of appreciation for the medications as well as the attention seemed truly genuine, especially given the Acehnese tendency to be straightforward and critical. However, even if biased, stories of therapeutic benefit and "awakenings" (Jenkins & Carpenter-Song 2005) were impressive. An elderly village woman described herself as an activist and explained how, after two months of IOM pharmacological therapy for anxiety, depression, and PTSD due to conflict-related chronic trauma, she awoke one day suddenly able to see her surroundings in a new way. For years she said everything seemed to be behind a screen, nothing was bright, everything was fuzzy and dark. Now she could see people clearly, colors were bright, as was the sky, the ribs on the deep green leaves of the plants visible. She laughed as she described her experience of this change, delightful and vivid. She told us her trauma story too. She described her life before the peace memorandum of understanding (MOU): always tense, always worried about the soldiers searching for her sons, and having to buffer her sons from the military. Her husband, who was much older than her, "did not leave the house much." Her eldest son was shot on his motorcycle while trying to escape soldiers who were harassing young men in the village. He later died in the hospital from his wounds. She told how women were exhausted by buffering the men. She told how she had to teach her grandchildren – and all the village's young children from the time they were toddlers – to protect the men, their fathers, grandfathers, uncles. "We taught them," she said, "when you see the sipahi, run, hide ... if they ask you a question, say nothing ... if they show you a gun and ask if your daddy has one of these, say no ... if there is a gun in the house, say no ... run, hide, do not speak to them." In twentieth-century Aceh, "sipahi" were Javanese or Batak from the Dutch colonial military viewed as "those who do evil." (excerpted with rephrasing from Good 2010, p. 61).

**Box 28.2: Case study 2**

A woman in her forties suffered from a long depression in response to losing her son, who fled to the capital city to escape the conflict only to be seriously injured in a traffic accident. Although near death, he recovered. During our visit, the woman told how after two months of antidepressants, she felt her normal self. She could cook and farm again. Her husband confirmed how she was deeply depressed and was now herself. Her husband was excited and voluble, wanting to talk about more than just his wife's depression and recovery. He laughed as a small group of men and women gathered round, talking about how excited they were that they could directly vote for their own choices and display the paper flag of the *Partai Aceh*, the newly formed political party formally representing much of the old GAM structure. In the past he said one could be killed for displaying this flag. "Now, we celebrate it!" The once-depressed wife smiled gently as her husband expressed how he and she felt "inside," about being able to vote for their party, and psychologically free to support those he trusted. Certainly the politics of peace provided succor to those who suffered "trauma" from years of conflict. The peace pill combined with psychopharmaceutical treatment appears to have significant efficacy in reducing remainders of violence (Good 2010).

communities, with houses and schools razed or burned, and villagers beaten, tortured, or killed, often in retaliation for attacks by GAM on the Indonesian military. Women told us of being forced to watch spouses killed and sons taken to the forest to be executed, and of their own beatings and humiliation. They complained of waking up with vivid images of what happened and being unable to return to sleep (Good *et al.* 2006, 2007, Grayman *et al.* 2009, Good 2010, in press). Constant fear and sadness made daily activities difficult, and anger made them unable to forget humiliating and traumatic events. Women's experiences were unique in that their anxiety and traumatic experiences often arose from their roles as buffers and protectors of men from military aggression. Post-conflict mental health treatment even three years after the peace was declared was needed by many; it proved to be helpful in addressing the mental health symptoms associated with remainders of violence. The Aceh experience of women as activists and protectors of men and not as merely victims is common in many conflict situations, and thus generalizable to larger post-conflict mental health issues (Fassin & Rechtman 2009, Siapno 2009, Good in press Hinton & Hinton in press). The interviews presented in Boxes 28.1 and 28.2 illustrate post-conflict experiences with therapeutic interventions as part of a mental health intervention.

## Future directions

We conclude with suggestions for future research on women's mental health and issues of empowerment. Efforts to measure empowerment among women paint a picture of inequality that, while uneven, is nonetheless pervasive. Women account for two-thirds of the world's poor and illiterate, with a fraction (less than 16%) of representation as elected officials. Outside of the agricultural sector, in wealthy and poor nations alike, women average 78% of the wages given to men for the same work. Furthermore, the obstacle of cultural attitudes that favor males is found to persist (Lopez-Claros & Zahidi 2005, p. 3). The overall picture of the status of women worldwide has been and continues to be unacceptable.

To remedy this state of affairs, Sen has made a compelling case for governments and agencies (governmental and non-governmental alike) to view women not as passive recipients of assistance but instead as dynamic engines for social transformation (Sen 1999, Lopez-Claros & Zahidi 2005, p. 3). For such to occur requires education, economic opportunity, and ownership rights. This is critical insofar as it may be that when women have decision-making control over economic issues, there is a greater likelihood of resources being spent on such basic needs as food, education, and health. While such efforts (including microfinancing) are worthwhile, their effect on women's mental health has not invariably been found to be salubrious (Fernald *et al.* 2008). Thus there remains a critical need for social change with the capacity to go beyond assistance to individuals and communities. Collaborative efforts by local actors must be pursued in tandem with the political will of institutional structures.

Drawing on a survey by the World Psychiatric Association and the Berlin Congress of Women's Mental Health, Stewart and colleagues (2001) emphasize the importance of health promotion (rather than

services) and on further interventions to address determinants of health (poverty, illiteracy, discrimination, and violence against women). For improvement of mental health, they argue that education is essential not only for knowledge acquisition but also for "gender consciousness (that is, the awareness that the inequities she suffers are not caused by her own short-comings, but are the result of discrimination and injustice) and should provide her with assertiveness and decision-taking capacity; in short, it should be empowering" (Stewart *et al.* 2001, p. 14). These educational goals should include critical gender thinking undertaken in light of local women's conceptualizations and perceived need (Niaz 2004; Douki *et al.* 2007). That is, empowerment must hold culturally experiential meaning to effect change. Furthermore, while "empowerment" is central in the literature on battered women, the manner and definition of finding one's own strength may be distinctive across persons and places. The intricacies of such processes must go hand in hand with cultural change of attitudes and practice surrounding violence against women, to target men to include not only physical violence but also the unrecognized but serious psychological damage of verbal abuse (Orava *et al.* 1996).

Future research on global mental health of women should be grounded in the lived experience of mental illness in an inexorably entangled nexus of relations of culture, power, gender, and meaning. Further study of the relation between lived experience and social forces in a globalizing world holds the potential to be incorporated into health policy and action that are key to addressing the mental health and well-being of girls and women worldwide (Cosgrove 2000, Doyal 2000, Nicki 2001, Biehl & Moran-Thomas 2009, Kostick *et al.* 2011). This task will help to improve the quality of research on women's experience of distress over the lifespan.

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