Advancing Learning and Innovation on Gender Norms

The social in 'psychosocial'

How gender norms drive psychosocial distress

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Setting the scene

It is increasingly recognised that norms are part and parcel of everyday life. They influence and guide attitudes and behaviours and they are produced and reproduced both formally and informally through a range of mechanisms and institutions, including social interactions. Many of these norms are gendered and discriminatory, often affecting girls and women more than boys and men. Hence, largely as girls enter puberty, they are often forced into early marriage, expected to bear male offspring, anticipated to drop-out of school and encouraged not to, or prevented from, seeing or talking to other males. The effects of these gendered norms are far-reaching and touch on most domains of a person's life, including on their mental health and psychosocial well-being and can result in girls and women facing isolation, depression, anxiety, fear and sometimes even contemplate or carry out suicide.

Before exploring these issues further, it is important to provide a brief background on the prevalence of mental health problems as well as their causes, as is conceptualised in the broader literature. Mental health problems affect more than one in four persons with disorders like depression affecting more than 350 million people globally (WHO, 2015a). Additionally, suicide, linked strongly in high income countries with depression, claims the lives of over 800,000 people annually across the globe (WHO, 2015b) and between 1990 and 2010, the burden of mental and substance use disorders increased by 37.6% globally (Whiteford et al., 2013). Mental ill-health and psychosocial problems often start during adolescence with common mental disorders (CMD), comprising anxiety and depression, being the most prevalent psychiatric illnesses among adolescents and young people worldwide (WHO, 2001a). Other studies show that suicide rates (often a result of un-diagnosed and untreated mental ill-health and psychosocial distress) among young people are increasing, with young people now the highest-risk group for suicide in around 30% of all countries; moreover, in China, India and the South-East Asia region, suicide is the leading cause of death among those aged 15 to 19 (Patel et al. 2007; WHO 2014; WHO 2016; Samuels et al, 2016).

A body of literature across various disciplines, though largely from psychology, explores the causes of mental ill-health and psychosocial distress showing that it is multifactorial and includes biological, psychological and social and environmental factors (see e.g. Chesney et al, 2015; WHO 2001; WHO and Calouste Gulbenkian Foundation, 2014). It is the latter group of causes i.e. the social factors and environmental, to which this piece contributes. In so doing, it focuses on mental ill-health and psychosocial distress at the milder end of the mental health disorder spectrum, also referred to as common mental disorders (CMDs), and largely to what have been defined internationally as internalising/emotional problems such as anxiety, depression, loneliness, sadness and somatic complaints, all of which can have a range of negative outcomes, including suicide. This piece also focuses largely on the Global South, though, critically such issues are just as pertinent to the Global North including in the UK where there has been considerable recent media attention on mental ill-health, largely again focused on CMDs and as a consequence of social and environmental factors (see, for example, this recent article in the Guardian which notes that being lonely can be as bad for ones health as having a long-term illness).

Some definitions

According to WHO, mental disorders are defined as "a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others," whereas biologically based disorders can include depression, bipolar affective disorder, schizophrenia and other psychoses, dementia, intellectual disabilities and developmental disorders including autism (WHO, fact sheet 2015a).

In addition to biologically based disorders, mental health can also be affected by psychosocial factors that cause distress. According to the Capetown Principles, "'psychological effects' are defined as those experiences that affect emotions, behaviour, thoughts, memory and learning ability and the perception and understanding of a given situation" (Capetown Principles, UNICEF 1997). These include social effects on well-being as a result of various factors such as poverty, war, migration, famine and climate change.

What sort of discriminatory gender norms lead to mental ill-health and psychosocial distress?

A range of social and environmental factors including rapid social change, migration, social isolation, conflict/post-conflict environments, unemployment and poverty, individual and family crises, changes in traditional values and conflict with parents, have been recognised by a range of scholars as being key drivers of mental ill-health and psychosocial distress amongst young people (e.g. Patel et al., 2007; Stavropoulou and Samuels, 2015; WHO, 2010). However, there remains relatively little in-depth discussion around the role of norms and specifically gender norms as underlying causes of mental ill-health and psychosocial distress. This is not to say that there is no awareness of gender norms as critical influencing factors. A recent and welcome report by Kapungu and Petroni (2017) does address this to some extent as does a recent newspaper article which explores the linkages between mental health of Indian women and patriarchy; often norms framed in terms of 'culture and context' are cited when discussing mental health and psychosocial needs of displaced persons or refugees in humanitarian contexts (see e.g. Hassan et al, 2015); and a range of innovative tools also dealing with issues of culture and context have been developed largely to be used in humanitarian contexts (see Stavropoulou and Samuels, 2015 as well websites for the Mental Health and Psychosocial Support (MHPSS) network and the Reference Centre for Psychosocial Support of the IFRC). Nevertheless, further study is needed to unpack and explore the pathways between context-specific gender norms and outcomes in terms of broader well-being, and particularly in relation to mental health and psychosocial well-being, and something which this piece starts to do.

Exploring the intersection of gender norms and mental health and psychosocial well-being during adolescence is particularly pertinent (though this is not to say that these issues are not also critical /play out during other stages of the life course) because this period is a decisive time in the life course when girls and boys start undergoing a range of changes as they transition from childhood to adulthood. It is during this period that developmental changes occur, and key skills are acquired such as those that relate to: health, physical and neurological development; social behaviours and attitudes; and education and employment. Bodily changes are also heighted at this stage, e.g. the start of menstruation and the development of breasts for girls and deepening voice and hair growth for boys. But perhaps more critically, the environment in which adolescents reside and, in particular, the norms which are embedded into the communities and which implicitly guide behaviour, attitudes and social interactions, start playing a pivotal role in their lives, also creating potential for mental ill-health and psychosocial distress (Gilligan, 1982).

Girls in particular during adolescence begin to encounter/confront the constraining role and influence of gender norms in a range of domains, from education and marriage to mobility and career aspirations outside the home. Often these gender norms translate as a decline in freedom for girls, i.e. freedoms that girls once experienced become severely restricted – while a younger girl could go out of the home relatively easily in a context such as Nepal, as she reaches adolescence she is no longer able to, or no longer able to do so on her own. Similarly, in Afghanistan and Pakistan, strict rules that enforce purdah are aimed to curtails girls' mobility in the public domain (Kabeer et. al., 2011). This is largely because at that age in these settings the girl is considered 'marriageable' and if she moves around on her own her 'honour' is at risk. This also often coincides with her being taken out of school, as of paramount concern for her parents is marrying her to a good family. As a result of all of this, the girl is likely to feel powerless or disempowered with an inability to control her own destiny and future; she can lose hope and she can also become anxious and fearful particularly if she is being married to an older man (still very common in many contexts) (see e.g. Ghimire and Samuels, 2014).

Post marriage, a young bride can also face psychosocial distress as she is often living away from her natal home in an area where she knows no one. As an outsider, she can easily become isolated with no opportunities for social interaction and therefore also no one in whom to confide. One young married

woman interviewed in Viet Nam poignantly told me that if it were not for her children, she would have taken her life a long time ago. She was depressed at having married young (in her case it was an elopement marriage), completely isolated and it seemed that her husband was abusing her (Samuels et al, forthcoming). China, which accounts for 26% of global suicides, is the only country where suicide rates among women are higher than among men, with between 25% and 40% more woman than men committing suicide each year. This is largely attributed to woman marrying young, being isolated, taking on a disproportionate burden of household work, facing large amounts of pressure to produce a male heir and being denied the same level of education as boys.

Norms also include largely implicit rules on how men should treat women, based often on contrasting and opposing notions of masculinity and femininity. Men, in short, should be seen to control women and particularly their wives, who in contrast are seen as inferior and subservient. In many contexts this male control can take the form of violence towards their spouse, both physical and psychological. This violence is accepted by many people, including the spouse, also because of a range of additional or intersecting norms that restrict the spouse from speaking about it. Such intersecting norms include a perception that violence between a husband and wife is a private matter, that it is perceived as a husband showing 'love' for his wife, and that leaving a husband or divorcing him would bring such shame and stigma to both the woman and her family that staying in an abusive relationship is preferable (see e.g. Naved et. al., 2017). While these notions are changing, and there are examples of positive role models and champions in all contexts, not only do these notions persist, but new forms of e.g. online violence are emerging, e.g. online or cyber violence (see Samuels et al, 2017). All of these behaviours affect the mental health and psychosocial well-being of girls and women. They feel undervalued, face isolation, fear, pain and also hopelessness, as they are usually unable to see a way out.

What interventions might mitigate psychosocial distress, and particularly from a gender norms perspective?

Meeting the psychosocial-related needs of adolescents

Awareness of the mental ill-health and psychosocial distress related challenges facing adolescents is increasing, and there is also increased awareness of the need to address mental health challenges more generally (see e.g. the welcome addition to the Sustainable Development Goals (SDGs) of the need to strengthen mental health by promoting "physical and mental health and well-being…for all" (Paragraph 26) with specific mental health goals in targets 3.4, 3.5, and 3.8, as well as the WHO Mental Health Gap Action Plan that aims at scaling up services for mental, neurological and substance use disorders for countries especially with low- and middle-income). However, the needs of adolescents in this area are largely unmet, and particularly in developing countries, with programmes being often age and gender blind. Additionally, while some countries may have some infrastructure and capacity (as well as appropriate policies) for dealing with severe mental health disorders (autism, schizophrenia, epilepsy) largely because they are easily recognisable, less severe forms of mental ill-health (depressions, anxiety, stress) often go unreported and untreated because they are more difficult to diagnose, are less visible, and often people are unwilling to come forward because of the associated stigma, preferring rather to deal with it either at home or alone (Samuels et al, forthcoming).

In order to address some of the underlying drivers of mental ill-health and psychosocial distress, in this case the discriminatory gender norms that underlie a lot of this distress, solutions need to include linking to programmes that unpack and address these range of gender norms. Thus, for instance, programmes targeting early marriage, linking also to notions of sexual purity for girls, restrictions of their mobility and freedoms, should include discussion on how such norms can lead to isolation, depression, anxiety and fear and ways of mitigating these need to be dealt with upfront. A cadre of service providers with social work or psychology backgrounds is also critical to address these less severe forms of mental ill-health and psychosocial distress, something which is often missing in many developing country contexts. Similarly, capacity building and tailoring services to the specific needs of adolescents, and indeed other age groups, as well as ensuring they are gender sensitive, is vital - adolescent girls are often fearful of, or unable to access reproductive health services often because providers are male and may have patronising attitudes. More generally, service provisioning needs to be informed by an understanding of the prevailing gender norms which underlie much of the mental ill-health and psychosocial distress that adolescents, particularly girls, face and which also affect the extent to which they are able and willing to access services.

Some success stories, but more is needed

Some positive mental health and psychosocial interventions exist in some contexts for adolescents and young people and could be adapted to different contexts and/or replicated and scaled-up. Many of these interventions address the isolation that adolescents, and in particular adolescent girls, may be feeling often as a result of underlying discriminatory gender norms. Thus, approaches often focus on addressing this isolation and include various school-based programmes, for example, the use of psychosocial counselling units in some schools in Viet Nam which have had positive results if done to high standards and the provision of parenting skills through the school environment (see Samuels et al forthcoming; see also Kieling et. al., 2011). Additionally, telephone hotlines have been a vital resource for adolescents and young people in many countries (e.g. Bangladesh, Viet Nam) facing stress and anxiety and similarly have had positive results. While the internet can lead to addictive behaviours and can cause stress, it can also be used as a platform for establishing virtual (and often anonymous) support for adolescents and young people facing distress. For instance, simple devices such as mobile phones have also made a difference to the lives of young brides in Nepal married out of their natal area as they are able to contain to maintain a connection with their family and friends back home.

Given that mental ill-health and psychosocial distress is also driven by social and environmental factors, including gender norms, it is critical to think beyond single focused or single sector responses. Thus approaches for empowering girls (also economically) have been shown in some cases to result in them challenging norms around early marriage); similarly, girl clubs have been shown as a positive tool for empowering girls. All of these approaches (and others) have instilled self-confidence, self-esteem and self-belief which in turn have had a positive effect on girls' mental health and psychosocial well-being. Awareness raising activities amongst norm enforcers (parents, parents-in-law, husbands, community elders) as well as key stakeholders in the broader service and policy environment of the critical role of gender norms in driving mental ill-health and psychosocial distress, are also critical. Finally, programmes keeping girls in schools[1] as well as those targeting early marriage[2] are critical to not only promote gender equality and gender justice, but to also combat mental ill-health and psychosocial distress which continue to affect many adolescents in developing country contexts.

[1] E.g. https://www.malala.org/brookings-report/keep-girls-in-school-through-secondary

[2] E.g. https://plan-international.org/sexual-health/child-marriage

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