Elena Mustakova-Possardt
Mikhail Lyubansky · Michael Basseches
Julie Oxenberg
Editors

Toward a Socially Responsible Psychology for a Global Era

Springer
Chapter 9
Overcoming Discrimination, Persecution, and Violence Against Women

Dana C. Jack and Jill Astbury

Oppression can only survive through silence.
Martin Luther King, Jr.,
...imposed silence about any area of our lives is a tool for separation and powerlessness.
Audre Lorde (1980, p. 9).

This chapter addresses how silence gives consent to conditions that are oppressive, and examines how voice is liberatory, providing an antidote to the power of oppression that survives through silence. Additionally, we focus on psychology’s responsibility to confront more proactively and systemically the interlinked issues of oppression, discrimination, and violence against women.

All over the world, voices of protest from disempowered, marginalized groups have brought injustices to light, and continue to provide the impetus for social change. The Civil Rights Movement, the Women’s Movement, the GLBT Movement, the “Arab Spring” of the Middle East, international campaigns to eliminate violence against women,¹ and many lesser-known protests have contributed to social transformation by breaking silence to detail and protest injustices. Silence about the issues of social inequality that affect people’s physical and mental health around the globe perpetuates the status quo and stalls attempts to create a sustainable global future for humanity.

We examine factors associated with the silencing of women and marginalized groups and how a socially responsible psychology, within this diverse world full of inequalities, can foster movement toward the core values and global priorities

¹ For example, the international “One Billion Rising” demonstration/strike/dance on February 14, 2013, to protest violence against women, occurred on almost every continent. The United Nations UNITE campaign to end violence against women and girls launched in 2008, and numerous NGOs and INGOs also organize to end violence against women and girls.

D. C. Jack
Fairhaven College of Interdisciplinary Studies, Western Washington University,
516 High Street, Bellingham, WA 98225, USA
e-mail: Dana.Jack@wwu.edu

J. Astbury
School of Social Sciences and Psychology, Victoria University, Melbourne, Australia
e-mail: jill.astbury@vu.edu.au

E. Mustakova-Possardt et al. (eds.), Toward a Socially Responsible Psychology for a Global Era, International and Cultural Psychology, DOI: 10.1007/978-1-4614-7391-6_9,
© Springer Science+Business Media New York 2014
espoused in the United Nations Declaration of Human Rights and the Earth Charter. We organize our discussion of factors associated with silencing around three themes: oppression, the relational self, and challenges to silence.

9.1 Oppression

Oppression is a powerful pathogen affecting physical and mental health in our world (Smith et al. 2009). As Martin-Baro (1994) argues, the root causes of oppression lie in the structures—political, economic, and cultural—and in the ideologies that undergird oppressive social conditions. These structures and ideologies affect people’s bodies and minds through daily experiences of violence, discrimination, poverty, and prejudice. Massive inequalities in health directly related to socio-economic standing are observable both within and across countries. For example, the lower a person’s socioeconomic position, the worse their health is likely to be (Marmot 2007; Patel and Kleinman 2003). Those in poverty have reduced access to food, shelter, education, water, and healthcare. Poverty itself is stigmatized in many countries, including in the U.S. Politically, those in poverty have the least powerful voice in the U.S. Congress to advocate for themselves. The same lack of political voice of people in poverty holds true globally.

Oppression particularly affects and silences women because of their social subordination and the violence directed against them. The well-documented gender disparity in rates of a range of psychological disorders mirrors the differential status, power, and unequal treatment of men and women globally (Astbury 2010). Women comprise 70% of the world’s poor (BBC 2008) and own around 1% of the world’s property (UN 2010). The 2006 World Development Indicators revealed that:

Unequal treatment of women- by the state, in the market and by their community and family- puts them at a disadvantage throughout their lives and stifles the development prospects of their societies (World Bank 2006).

9.1.1 Violence Against Women

Violence against women is the most pervasive human rights violation in our world (UNIFEM 2007) and leads to their mental and physical health problems (International Consensus Statement on Women’s Mental Health 2006). Such gender-based violence, including child sexual abuse, sexual violence in later life, and intimate partner violence is associated with a significantly elevated risk of a range of negative mental health outcomes. These outcomes encompass increased rates of depression including postnatal depression and dysthymia but also anxiety, suicidality, PTSD, panic disorder and certain phobias, substance use disorder, somatisation, and dissociative disorders with high levels of psychiatric comorbidity (Astbury and Cabral
It is unlikely to be a coincidence that most of these disorders\(^2\) are characterized by a significant gender disparity in prevalence rates.

The right to health is explicitly identified in a number of human rights instruments, including the Universal Declaration of Human Rights (1948), the International Convention on the Elimination of All Forms of Racial Discrimination (1965), the International Covenant on Economic, Social, and Cultural Rights (1976), the Convention on the Elimination of All forms of Discrimination against Women (1979), and the Declaration on the Elimination of Violence against Women (1993). However, violence against women—the most common factor that puts their health at risk—continues globally through selective female foeticide, infanticide, childhood sexual abuse including forced child marriage, intimate partner violence, and adult sexual violence (Krug et al. 2002; Garcia-Moreno et al. 2006). The International Labor Office (ILO) (2005) report on forced labor reported that women and girls predominate among those trafficked for forced economic exploitation (56% women and girls compared with 44% men and boys) and are overwhelmingly at risk of being trafficked for forced commercial sexual exploitation (98% compared with 2%).

Socially responsible psychology has a vital role to play in documenting and speaking out about the links between violence against women, women’s subsequent psychological distress, and how violence against women contributes to the instability of societies. Despite feminist psychologists’ emphasis on how underlying ideologies and social contexts support violence against women, research models regarding social factors that predict depression in women often use language/terms that mask the critical psychological impact of such human rights violations. Moreover, some studies slight social justice issues by using what appears to be “objective” and “scientific” language. For example, in a Burden of Disease (BOD) study in Victoria, Australia (Vos et al. 2006), intimate partner violence (IPV), including sexual violence, was investigated as a health ‘risk’ factor and compared with a range of previously well-investigated health risk factors. This study found that IPV constituted a greater risk for ill-health among women under 45 than all seven of the other major health risk factors examined, such as high body weight, high cholesterol, high blood pressure, harmful alcohol, illicit drug and tobacco use, and physical inactivity. IPV was associated with more than twice the risk to health as the next most important factor, illicit drug use, which contributed to less than 4% of the BOD. The largest contribution to the burden of disease associated with IPV was poor mental health. Depression, anxiety, and suicide together contributed to 73% of the total disease burden associated with IPV. Harmful health-related behaviors (tobacco, alcohol, and illicit drug use) that often co-occur with poor mental health accounted for another 22% of the disease burden attributable to IPV.

\(^2\) With the exception of substance use disorder where men predominate.
Psychologists interested in social justice issues can be more aware of the social/political consequences of the language and naming of variables in studies that include IPV. Astbury (2010) has argued that using the term 'risk factor' rather than human rights violation has unwittingly deflected our attention from the possibility that such 'risk' and 'vulnerability' factors might stand as proxy variables for a range of rights violations. Moreover, if rights violations are occurring, but are not being named as such because the biomedical, epidemiological terminology of 'risk' serves to conceal rather than elucidate them, then it can be argued that such language is likely to be, as Mann (1999) puts it, "inapt and inept" in identifying the important forms of human suffering and injuries to human dignity that are taking place. The inappropriateness of using the standard term 'disorder' to designate the suffering associated with human rights violations, as in 'dignity disorder,' 'humiliation disorder' or 'unfairness disorder,' supports this assertion (Astbury 2010).

One way of continuing to break the silence around the pervasiveness of violence against women is to continually highlight its tie with women’s mental health problems. The strength of the evidence on the mental health effects of gender-based violence mandates that competent practice by clinical psychologists must ascertain whether and how a woman’s mental distress might be associated with the violation of her dignity or other human rights, including the right to liberty and security of her person. Such violations must be identified and addressed as a matter of priority. Women are meant to have an inalienable human right to dignity and to live in safety; the mental health benefit of living in freedom from violence cannot be underestimated. In one study, the cessation of violence for women with a history of physical or sexual abuse and psychological abuse resulted in a 27% decline in the likelihood of depression. This increased to a 35% decline in women who had experienced multiple forms of abuse (Kernie et al. 2003).

Thus, mental health interventions by socially responsible psychologists cannot be confined to the diagnosis and clinical treatment of psychological disorders. Astbury (2010) asserts that such an approach fails to address the multiple instances of unfair and violent treatment that significantly predict depression and associated mental health conditions such as PTSD in women. By placing these matters outside the parameters of clinical concern, a major opportunity is missed to reduce and speak out about preventable causes of depression and human suffering (WHO, ICPE 2000). By contrast, a focus on human rights violations centralizes their contributory role in the development of certain forms of poor mental health, such as depression, PTSD, and anxiety. The language of rights steps beyond the terminology of scientific, neutral, decontextualized ‘risks’ into a more political sphere. Within a rights framework, countries that are signatories to various human rights conventions that include the right to health become accountable for the health inequalities that violence against women creates.

Existing research on risk factors for depression has not been informed explicitly by a human rights approach, therefore, much of the psychological suffering deriving from human rights violations is unlikely to have been named or documented, let alone measured. The naming of different forms of human suffering
logically precedes the possibility of being able to count or quantify them: "Child abuse did not exist in meaningful societal terms until it was named and then measured; nor did domestic violence" (Mann 1999, p. 449). Instead of labeling as "depression" the suffering, low self-esteem, and demoralization caused by violence directed against a woman, perhaps we should formulate a new term that flags these symptoms as created by human rights abuse, such as "violence-induced depression": Otherwise, "depression" easily denotes an individual disorder that directs attention away from the social context.

**Naming that implicates the social context as critical in precipitating mental health problems may help psychology step away from the prevailing individualist assumption that mental distress is located in individual brains and minds.** This assumption reinforces a deficit model of mental illness—that is, that social and mental problems arise because of some fault that lies within the individual's biochemistry, coping skills, and/or cognitive response to an event. Prevailing clinical practice centers on changing the person through individual therapy or medication-based treatment rather than changing the context. Such a focus on individualized treatment is reinforced by the DSM and the third party payment system, which typically requires a DSM diagnosis for treatment reimbursement (Gordon 2010). Unfortunately, both economic and dominant values in the US serve to reinforce the pattern of individual and medication-based treatment over preventative mental health services or client advocacy efforts. As multicultural and liberation psychologists have argued, much of counseling is based on a "remedial medical model of service delivery," where a person's problem has developed after experiencing destructive environments, and the counselor works to solve the problem within the person's head (Vera and Speight 2003). Instead, socially responsible psychologists can aspire to a more activist approach that includes working for change on community and structural levels, including preventive mental health services and activism.

**Thus, we urge that advocacy and activism skills be added to the clinical and research skills taught to psychologists as part of their professional education.** When psychological distress originates in oppressive social structures that rob people's dignity and legitimize their ill treatment, then research and interventions must address these broader factors—political, social, economic, and cultural—to create/restore people's emotional wellbeing. If this is true, then an accompanying imperative is that where oppression exists and egregious rights violations occur they must be identified, voiced, and opposed by psychologists in their work, whether that occurs within or outside the consulting, teaching, or research room. While these aspirational goals are also espoused by multicultural, feminist, community, and cultural psychologists, they lie at the heart of what is meant by a socially responsible psychology.
9.1.2 Discrimination

Discrimination, poverty, and violence disproportionately affect minority groups (such as ethnic/racial groups, sexual minorities, and people with disabilities) around the globe. In the United States, racial discrimination negatively affects the physical and mental health of members of minority groups (Williams et al. 2003). Ethnic minority women in poverty experience more discrimination than men in poverty because of the intersections of race, poverty, and gender (Belle and Doucet 2003). Specifically, a 5-year longitudinal study of African American women in Detroit found that higher self-reports of discrimination are associated with increasing depressive symptoms over time, and to declining self-rated general health status (Schulz et al. 2006).

Lesbians, gays, and bisexual individuals also experience discrimination because of stigmatized sexual identities through a range of factors such as health care barriers, legal inequalities, and physical threats (Meyer 1995). Individuals who have dual or triple minority statuses arising from ethnicity, sexual orientation, and female gender are found to be at elevated risk for psychological and substance use morbidity, especially lifetime histories of suicide attempts (Cochran et al. 2007). Few studies have focused on depression among Black lesbian or bisexual women who face triple jeopardy, yet such studies are critical for guiding mental health interventions (Bowleg et al. 2004).

Kleinman (1995) has argued that perceiving trauma in the context of the individual is politically motivated, because it is easier to make treatment recommendations than it is to confront the social, political, and cultural power structures that created the trauma in the first place. Yet psychologists are also citizens, and assuming the posture of a passive bystander is indefensible in the face of chronic social injustice. Consequently, we have an ethical and social responsibility to identify and actively critique injustice that we know causes psychological injury and harm. Preventing or reducing exposure to traumatic experiences and traumagenic ideas is likely to be much more effective in reducing the burden of psychological disorders in any community than attempting to treat them after they develop. This is especially true for marginalized communities and low income countries where access to psychologists and psychiatrists is so limited.

One study illustrates how political power structures affect mental health, specifically, how exposure to social discrimination creates psychiatric symptoms. While most studies of LGB ethnic minority groups focus on individual-level factors, Hatzenbuehler et al. (2010) examined the impact of living in states that instituted bans on same-sex marriage during the 2004 and 2005 elections and the prevalence of psychiatric morbidity among lesbian, gay, and bisexual (LGB) populations. This 3-year longitudinal, nationally representative study found increases in psychopathology among LGB respondents in any mood disorder (36.6 % increase), generalized anxiety disorder (248.2 % increase), and any alcohol use disorder (41.9 % increase). They also found a 36.3 % increase in psychiatric comorbidity. These psychiatric disorders did not increase significantly
among LGB respondents living in states without constitutional amendments, and no increases of the same magnitude were found among heterosexuals living in states with constitutional amendments. Such findings emphasize the impact of a discriminatory socio-cultural context on the mental health of LGB individuals, and the importance that psychologists continue research to demonstrate the effects of oppressive social policies and work to overturn them. (see Jack et al. 2013)

The choice of topics that are investigated and the methods and research questions used in the investigation reflect psychology’s values and priorities. After a long history of studies done primarily by men with male subjects, multicultural and feminist voices are increasingly present in the profession and calling for attention to underrepresented topics. Yet, this is not enough. Socially responsible psychology needs to join the call to prioritize under-represented areas of investigation. Voices of dissent and challenge need to be heard and not ‘shut up and shut out’ (Reid 1993) of psychological research and publication. Apart from the specific areas chosen for inquiry, psychological research often silences the voices and perspectives of participants through its methodologies. The emphasis on statistical findings with a concomitant devaluation of qualitative research often results in promoting the questions and theories of the investigator, while the “participants” remain silent.

A socially responsible psychology needs to listen as well as measure, to learn from people rather than simply measure some of their aspects. Listening can be a constitutive element in our methods as we move to a deeper appreciation of how psychology can become socially responsive. Moreover, to move the discipline of psychology toward socially responsible practice and research, we suggest that psychologists focus on the mechanisms/processes by which human rights violations and structural inequalities affect not only people’s psychological functioning but their interpersonal interactions on intimate and community levels. As generations of feminist psychologists have asserted, the personal is political.

9.2 The Relational Self

A cascade of recent evidence from a variety of disciplines—neuroscience, evolutionary theory, biology, and psychology—affirms that the self is social. The psyche itself is interdependent. Even the brain is a social organ: Its very structure and biology are shaped by social contexts and interpersonal interactions throughout life (Cozolino 2006). A plethora of studies document the importance of positive relationships to healthy physical and psychological functioning (Kawachi and Berkman 2001). The mind exists in dynamic interactions with the biological systems of the body and brain and with the social world in which it is embedded. Social events interact with biology in the genesis of the trauma response (van der Kolk 1988). In addition to violence, negative social events, such as judgmental responses to victims of rape (Ullman and Filipas 2001) or to disclosure of PTSD by returning members of the armed forces (Leibowitz et al. 2008), are known to heighten symptoms and negatively impact subsequent mental and physical health.
Within the world’s population of over seven billion, of which only one billion are of white European and North American ancestry, psychology’s longstanding notion of the separate, autonomous self is a “peculiar idea within the context of the world’s cultures.” (Geertz 1973, p. 34). Yet, because Western nations have had economic, political, and cultural power, their world views (e.g., the importance of autonomy and self-determination) have dominated theories of the psyche and approaches to mental health (Marsella and Kaplan 2002). In general, Western ethnocentrism has alienated and separated us from other cultures and their richness, preventing our understanding of healing practices rooted in different understandings of the self.

The relational nature of the self highlights the dangers of social disconnection for mental and physical health. For example, neurochemistry responds to both internal (genetic) and social variables: the anticipation of social exclusion leads to a firing in the anterior cingulate, the area of the brain that registers both physical and social pain. Being left out, being marginalized personally, or as part of a social group, is experienced as real pain (Eisenberger and Lieberman 2004). Even the threat of separation engages the attachment system (Mikulincer and Shaver 2010) and activates neurobiological systems and higher order self-regulatory cognition (Panksepp 1998). Conversely, sharing one’s feelings with others during difficult times stimulates the release of oxytocin, a hormone that reduces stress (Taylor et al. 2000). In addition to affirming the pain of individual isolation, findings regarding the relational nature of the self offer alternative ways of understanding how social factors affect the body and the mind. Such findings also clarify why the threat of social censure through discrimination/marginalization is a powerful tool of social control. They also reveal why social connection and experiences of positive collectivity protect mental health.

9.2.1 Silencing the Self

What are the processes by which the social and political become the personal? How can oppression silence a person, a group? An individual-level counterpart to the silencing created by socially oppressive structures and ideologies, is self-silencing. That is, on the individual level, when it feels too dangerous, shaming, or socially discrepant to voice one’s feelings or opinions, a person “silences the self.” The theory of Silencing the Self (Jack 1991; Jack and Dill 1992; Jack and Ali 2010), based within a relational model of the self, regards social factors and cognitive factors as inextricably linked and interactive. Self-silencing theory calls attention to the social, interpersonal context of depression and mental distress, particularly how social inequality and gender live in one’s mind to affect everyday interactions and the experience of self. Research finds that “gender specific aspects of socialization practices and material social power are reflected in self-silencing thoughts and behaviors” (Jack and Dill 1992, p. 99). The theory is also based on assumptions about the centrality of relationships in people’s lives, and on the depressogenic effect of social/relational disconnection.
Oppression creates and demands silence. Self-silencing works as a strategy for survival in situations that hold threat (Jack 1991; Woods 2010). It can be used to create an outer appearance of conformity to social/relational expectations and/or to offset the stigma that may result from exposing one’s socially discrepant feelings. Self-silencing, however, leads to disconnection, which leaves one vulnerable to a host of mental and physical ills. Importantly, self-silencing does not refer only to one’s literal voice, but functions also as an indicator of isolation from intimate others, one’s community, and one’s wider society.

The dynamic of self-silencing has been measured by the Silencing the Self Scale (STSS; Jack and Dill 1992) across numerous cultures (Jack and Ali 2010). Sentences in the STSS present themes heard in a qualitative, longitudinal study of depressed women (Jack 1991). In their narratives, women focused on their relationships; establishing and keeping positive connections was evident as a primary motivator. It was clear that depressed women’s cognitive/relational schemas about how to make and keep relationships reflected a set of attachment behaviors based on social inequality. These relational schemas, based on prevailing standards of feminine “goodness,” led women to put others’ needs first and to silence certain feelings, thoughts, and actions in order to avoid interpersonal conflict or danger. Self-silencing, in turn, is hypothesized to contribute to a fall in self-esteem and feelings of a loss of self, inner division and disconnection. This dynamic, deeply tied to social context, has been found to predict depression across a number of studies and cultures (Jack and Ali 2010).

The four subscales of the STSS reflect the dynamic revealed in depressed women’s interviews. These are Externalized Self-Perception (seeing and judging the self by external standards), Care as Self-Sacrifice (securing attachments by putting the needs of others before the self), Silencing the Self (inhibiting one’s self-expression and action to avoid conflict and possible loss of relationship), and the Divided Self (presenting an outward self that differs from inner experience; the experience of inner division). The first subscale taps standards used for negative self-judgment; the second and third measure schemas guiding interpersonal behavior; and the fourth reflects the phenomenology of depression. Subscales are interrelated and together form the construct of silencing the self; they are considered to work together in an interactive fashion so that as one aspect is heightened, so are the others.

Self-silencing reflects one process by which the social and political become the personal. Dominant in depressed women’s narratives was a moralistic voice that told them how they “should” behave/feel/love. This voice was experienced as part of the self, but reflects dominant beliefs about a “good woman.” Jack (1991), (1999) designated it as the “Over-Eye;” it is measured by the subscale, Externalized Self-Perception. This subscale links the personal to the political/social: It measures the degree through which a person sees and judges the self through others’ eyes. Following its dictates is experienced as a moral imperative; veering from its demands is experienced as dangerous. For oppressed groups, this includes the process through which individuals begin to see themselves as they are viewed by the dominant other. Because the Over-Eye reinforces conventional “morality”
or dominant values, it is often accepted as 'the way things are,' particularly when supported by the authority of religion. It also reinforces the blending of morality and gender ideology, as what a "good woman" is like, or as what a "strong man" would do or be. Self-silencing does not directly reflect gender roles; rather, it may shed light on how gender role adherence is required by levels of inequality or intolerance in one's social/relational context.

Higher levels of oppression are associated with higher endorsement of self-silencing and depressive symptoms across specific contexts. For example, self-silencing has been found to be significantly higher among women who experience intimate partner violence (IPV) (Jack and Dill 1992; Woods 2010), or among women who are stigmatized, such as low-income, ethnically diverse women with HIV/AIDS (DeMarco 2010). Functioning as mental mediators between the social circumstances of a woman's life and how she responds to them, self-silencing schemas may provide a new focus for culturally and socially grounded interventions that target psychological distress from a contextual, relational perspective.

Thus, we argue that self-silencing can stand as a proxy for oppression. Self-silencing is highest (most pronounced) in intimate relationships of inequality or abuse, and such relationships partake in, or mirror, entrenched gender inequality at the societal level. Fear and inequality critically determine the levels of self-silencing (Jack 1991; Jack and Ali 2010). Self-silencing occurs in both the private and the public spheres. In the private sphere, if women raise their voices, they are much more likely to face retaliation than the men who perpetrate violence against them or on whom they are financially dependent. In the public sphere, across the world, if women speak up about violations of their rights such as reporting a rape, it is likely to be futile and retraumatizing. If, for example, the complaint makes it to court (only a small proportion of complaints get this far), the woman is typically portrayed as an "incredible" witness or worse, a consensual and willing sexual partner. Thus, the political and personal are inextricably linked: self-silencing may be understood as a form of self-oppression that personalizes wider social structures and ideologies.

**9.2.2 Self-Silencing and Gender**

Silence and voice are not opposites. Rather, the two organize and co-create each other. Silence can signify power as well as powerlessness. As Charles De Gaulle said, "Nothing strengthens authority so much as silence." Ideologies of masculinity affect men's self-silencing and can reinforce their power; men's motivations for self-concealment through silence appear to differ from women's (Smolak 2010). From the beginning, studies have found that men usually score higher on the STSS than do women (Gratch et al. 1995). Yet, while self-silencing is generally associated with depressive symptoms in women, findings among men are less consistent (see Jack and Ali 2010). Why might this be?
Ideologies of masculinity affect men through an emphasis on individualism, power, control, stoicism, and self-sufficiency. Studies have found that gendered socialization practices through restrictive norms defining how men should think, feel, and behave shape how they respond to negative affect such as vulnerability, sadness, and depression (Addis 2008). For example, norms of masculinity lead many men to experience and express negative affect through expressions of anger, substance abuse, and/or withdrawal (Moller-Leimkuhler 2003). Men complete suicide four times more often than women, even though women’s rates of depression are twice as high as men’s in developed and developing countries (Bromet et al. 2011; Kessler et al. 1994). The World Health Organization predicts that by 2020, depression will become the number two health burden in the world, with recent studies showing that the gender gap in rates of depression may be narrowing as younger men report more depression (Moller-Leimkuhler 2003). When combined with men’s social power over women and men’s reluctance to seek treatment, addressing ideologies that foster violence against women becomes even more urgent.

Men’s untreated depression carries serious consequences not only for them, but also for women, children, and communities. Psychologists need to ask: What changes occur in men’s attitudes when a society manages to reduce violence against women? In what social contexts do gender ideologies regarding masculinity become less powerful? In what contexts are men less prone to silence their own vulnerabilities and ask for help? These questions are especially urgent as thousands of troops return with mental distress from long war engagements in Afghanistan and Iraq.

We suggest that voice and silence offer a unifying perspective that allows examination of patriarchy’s impact on men as well as women. If silencing is understood to be a relational process—rather than a personality style or individual trait—then Silencing the Self theory can help us to situate questions of gender not simply in the realm of either/or dichotomies but in a more fluid domain that tells us about disempowering contexts. Further, if gender is reproduced through enactment in social relations, does the differing use of silence by women and men play a key role in this reproduction? Clearly, silencing is one of the strategies used to create and maintain dignity impugning social environments for oppressed groups.

Finally, how do specific contexts such as discrimination and stigma foster self-silencing in men, and how might those be linked to violence, domination, and disconnection? We cannot hope to reduce violence against women without changing the gender ideologies that affect men’s understanding of power, dominance, and gender relations. At the same time, the skewed power that men continue to hold in most countries of the world must be addressed and changed in order to move toward the goals of the UNDHR and Earth Charter. As an example of how this might occur, we turn to the Triple Jeopardy Project.
9.3 Challenging Silence: The Importance of Counter-Narratives to Gender Ideologies

While gender-based violence is acknowledged as an important public health and human rights issue, public recognition that violence against women in their own homes is a social evil and a criminal act only emerged after concerted political action by women to 'break the silence' about the violence in their lives. Research into the health consequences of domestic violence by psychologists, other social scientists, and clinicians followed rather than preceded the work of grass-roots women activists to draw attention to the multiple harms caused by such violence. Even now, when a large body of evidence exists on the negative physical, reproductive, psychological and socioeconomic consequences of violence, most of it comes from high income countries of the geographical North such as the United States. It is unclear whether the risk factors identified or the interventions developed from this research apply equally well to low and middle income countries of the South which are more populous and where different social and cultural arrangements prevail.

The ‘WHO multi country study on women’s health and domestic violence against women’ (Garcia-Moreno et al. 2006) sought to address this geographical and research funding bias by conducting research in ten, predominantly low and middle income countries. However, large geographical gaps in knowledge remain. Only one country in South East Asia, Thailand, participated in the WHO multi-country study, and there is a significant need for increased research in this region of the world. In South East Asia and Asia, more generally, gender-based violence (GBV) intersects with and reflects a range of gender-related practices that disadvantage and harm women. These include son preference, abandonment and neglect of the girl child, trafficking of girls for sexual exploitation, discriminatory feeding practices, child marriage, dowry, honor crimes, and forms of burning, including acid and stove ‘accidents.’

9.3.1 The Triple Jeopardy Project

We use the findings of a study underway in Cambodia to illustrate the critical importance of public/political counter-narratives that contradict prevailing gender ideologies related to “a good wife” who should be submissive and please her husband. The study also provides an example of conducting research that ties such discourses (e.g., gender equality policies, domestic violence laws) to intimate gender relations, violence against women, and women’s mental health. Finally, it offers a demonstration of the potential role of socially responsible psychology in the current realities of male dominance and violence against women that are so prevalent in our world. The study is a collaborative project between Australian and Cambodian partners, involving Monash University, CBM-Nossal and the
International Women’s Development Agency (IWDA) in Australia and Banteay Srei, an NGO working on positive change and empowerment for women, and the Cambodian Disabled People’s Organization (CPDO) in Cambodia. Through inter-country collaboration, the research aspires to be culturally sensitive, and thus to avoid the “itinerant researcher” trap of a Western psychologist who simply arrives in a culture and imposes Western values and beliefs (Trimble et al. 2010).

The study, ‘Triple Jeopardy: Gender-Based Violence, Disability, Rights Violations and Access to Related Services among Women in Cambodia,’ examines how multiple sources of vulnerability, including disability and violent/unfair treatment, affect Cambodian women’s right to health and health care. One of its goals is to examine how cultural gender norms, gender-based violence, and disability contribute to high levels of psychological distress among the 354 women who participated in the survey component of the study. Cambodia has made no discernible progress toward its Millennium Development Goal (MDG) to reduce maternal mortality and only “slow” progress toward gender equality, with little change in high rates of violence against women (AusAid 2010). More specifically, according to the 2011 Human Development Report Cambodia ranks 99 out of 145 countries on the Gender Inequality Index (GII), a new measure of gender inequality which has replaced the Gender related Development Index (GDI) and the Gender Empowerment Measure (GEM).

Although progress toward gender equality in Cambodia is slow, change is nevertheless taking place. Its uneven nature is characterized by positive legislative change on the one hand, and persistent traditional gender-based codes of conduct, discrimination, and gender-based violence on the other. The World Report on Violence and Health (Krug et al. 2002) makes clear that social and cultural factors strongly shape the probability that gender-based violence will occur and likely lead to corresponding legal, health, and social consequences. Thus, it is critical to better understand the role of long-held cultural norms and gender-based codes of conduct that undermine efforts to reduce gender-based violence and promote gender equality.

In Cambodia, traditional beliefs about the relative worth of men and women are expressed in the common Cambodian saying that ‘Men are gold and women are cloth.’ They are articulated at much greater length in the Chbab Srey, or the women’s code of conduct. Gender norms and beliefs are, of course, found in every society, but they are not typically disseminated in a formal way through the school system. Cambodia is unusual in this regard. The Chbab Srey was taught as part of the school curriculum until 2007.

In Cambodian society, Chbabs provide prescriptions for proper behavior and comportment in all human relationships. They include a men’s code (Chbab Proh), a grandchildren’s code (Chbab Kun Cau), and a code covering ancient advice (Chbab Backy Cas) and one covering inheritance (Chbab Keru). The Chbab Srey is

---

3 This mixed method study is funded by AusAid, the Australian aid agency, through an Australian Development Research Award (ADRA).
important, because it represents a profound obstacle to gender equality and the reduction of violence against women. The beliefs promulgated in the Chbab Srey remain highly present in Cambodian society and co-exist with inadequate implementation of the new anti-violence laws regarding women (LICADHO 2007).

In what follows, the impact of these two contradictory discourses will be explored. On the one hand, a human rights and gender equality discourse is being promoted in Cambodia via its commitment to various human rights instruments such as CEDAW, its passing of anti-violence legislation and promotion of the rights of persons with disabilities and its support for the gendered human development aspirations articulated in the MDGs. On the other, the continuing influence of the Chbab Srey nourishes beliefs that champion female and wifely subservience and helps to maintain an unjust status quo.

The shadow report by Cambodian NGOs on the ‘Implementation of the Convention on the Elimination of All Forms of Discrimination Against Women In Cambodia, 2010’ also comments on the difference between the de jure and de facto situation in Cambodia that arises from its socio-political context. The report singles out the ongoing observance of the moral codes and social practices promoted in the Chbab Srey in sustaining gender inequality. Its codes of conduct regulate the female population, impair women’s movement, engender high rates of illiteracy and poverty, reduce occupational choice and control over resources, and are responsible for low rates of political participation (NGO-CEDAW and CAMBOW 2011). For minority groups, including women with disabilities who face additional discrimination, the situation is even worse.

Continued social progress across the world is dependent on reducing the gap between the de jure and de facto situation, as in Cambodia. Central to this task is overcoming the ideological power over women’s minds and lives that are inherent in the Chbab Srey. The extent to which contemporary Cambodian women have begun to question the strictures of the Chbab Srey is one useful indicator of progress on this front.

The Triple Jeopardy Project therefore sought to document current beliefs held by Cambodian women about traditional gender roles that are consistent with the ideas of the Chbab Srey. The objective was to discern whether fractures in the pattern of beliefs promulgated in the Chbab Srey are taking place and if so, whether they are connected with self-silencing and psychological distress. In addition, the role of partner violence and disability in psychological distress was explored.

The design of the study, participants, and findings from the study will be only summarized here, as they are detailed elsewhere (Astbury 2012). The survey questionnaire was based on the WHO Multi Country study (Garcia-Moreno et al. 2006). It was administered via a face to face interview and shortened in length to reduce the burden on participants, particularly those with disabilities. Half of the participants were women with disabilities and half were women without disabilities, allowing for comparison of the two groups, where appropriate. The sample reflected the distribution of population in Cambodia with approximately a quarter of participants coming from urban sites and three quarters from rural sites.
Items with which the participants were asked, in the interview, to agree or disagree gauged the level of their endorsement of traditional gender norms within their marriages, partnerships, or families. These norms govern the attributes of the ‘good wife’ and beliefs about ‘good’ interpersonal behavior of women as found in the Chbab Srey. In the Chbab Srey, a high ranking mother, Queen Vithimolia, gives advice to her dear daughter on how to be a good wife. The advice is exhaustively spelled out in the seven pages of the poem, which is believed to date back to the sixteenth century.

The following provides an example of the traditional gender norms and the attributes of the good wife from the Chbab Srey with which participants agreed or disagreed: Item 3. It is important for a man to show his wife/partner who is the boss. The Chbab Srey says, ‘If you don’t feel afraid of your husband’s feeling….we call you a woman who lacks good character.’ ‘Don’t speak in the way that you consider him as equal.’ Seventy-one percent of participants agreed with this statement and others in similar vein. These findings represent a ringing endorsement by the majority of participants of male dominance and female acquiescence to male authority within the family. They also indicate participants’ agreement to speak in a subservient manner, to craft their words to reflect their gender inequality. The only traditional gender norm endorsed by less than half the participants was the belief that a wife had an obligation to have unwanted sex with her husband. For four other items, levels of endorsement ranged from 51 to 88% of the sample and most, but not all women, accepted the beliefs promulgated in the Chbab Srey that equated the good wife with someone who would suppress her anger, never disagree with her husband, be afraid of his feelings and accept the importance of a man showing his wife who is the boss.

Such ideas are inimical to those espoused in various rights discourses and encourage self-silencing in accord with social mores that call for women’s silence. They present a huge obstacle to efforts by the Cambodian government, NGOs, and international donors working in Cambodia to promote gender equality. They also pose a challenge to psychologists: How can we have an impact on this central issue of social justice when the majority of local women are themselves in agreement?

Additional findings from the TJP shed some light on this important question. Even though another aspect of the study found that participants agreed that there were ‘good reasons’ for a man to hit his wife, the study found that women who disagreed with gender norms had significantly lower levels of psychological

---

4 As noted already, 354 women participated in the survey interviews. They were aged between 18 and 45 years with a mean age of 31.7 years (sd = 8.3). Just over three quarters of the sample had ever attended school (76.5%). Of the 23.5% who had never attended school, women with disabilities predominated. For women who had some schooling, more than two-thirds (68.8%) had only attended primary school. Just over 60% reported that had ever been married or partnered.
distress than those who agreed. These findings strongly suggest that a repudiation of traditional gender norms and a range of justifications for male partner violence are linked with better mental health. Finally, a clear gradient in the level of psychological distress was found which varied according to women’s views about sexual rights in marriage, their experiences of partner violence, and whether or not they had a disability. A series of comparisons between women who accepted rather than rejected traditional, culturally based gender norms and justifications of partner violence clearly revealed that these beliefs do not confer a psychological benefit on those who hold them. On the contrary, the women in this study who agreed with such ideas had higher levels of psychological distress than those who repudiated them. One of these ideas, namely acceptance by some women that refusal to have sexual relations gave their husbands a good reason to hit them, interacted with actual violence and disability to result in almost pervasive symptoms of psychological distress. Women who held this belief reported symptoms of psychological distress on 80% of the items of the SRQ compared with 50% of women who disagreed with this belief. Thus, disagreement with the rationale for partner violence was linked with less psychological distress.

Beliefs about traditional gender norms consistent with advice from the Chhab Srey continue to exert a powerful hold on the minds of the majority of Cambodian women who participated in this study. The same is not true for most of the ‘reasons’ justifying partner violence with the exception of the near universal approval of the view that a wife’s infidelity was a good reason for their husbands to hit them. In contrast, the majority of women rejected all other ‘reasons’ justifying partner violence; levels of rejection ranged from 65% of women who disagreed that a woman’s disobedience was a reason she should be hit, to 93% of women who rejected the idea that asking a man whether he had other girlfriends constituted grounds for partner violence. It is probable that these attitudes are linked to awareness by women that violence against them is wrongful behaviour and a criminal act. If this is the case, the Cambodian Millennium Goal that seeks to have 100% of the Cambodian population aware of these facts by 2015 is within reach, but only if there is accompanying change in men’s attitudes, beliefs, and behaviors.

Socio-culturally produced systems of oppressive beliefs like those apparent in the Chhab Srey militate against female autonomy, gender equality, violence reduction, and women’s right to mental health. In contrast, resistance to such belief systems, even if violence occurs, is associated with less psychological distress than does acquiescence. Speaking up, even when this occurs within one’s own mind, appears to support a sense of psychological wellbeing, because it symbolizes a rejection of social beliefs and cultural norms that, when internalized, are deeply incompatible with one’s dignity as a person. Importantly, evidence from

---

5 Psychological distress was measured by the SRQ (Beusenberg and Orley 2004) which is a 20 item, well-validated measure of psychological distress with a minimum possible score of 0 and a maximum score of 20. Higher scores on the SRQ indicate an increased level of psychological distress and lower scores indicate a decreased level of psychological distress.
the current study suggests that laws, policies, and mass social marketing campaigns designed to make women aware of their inviolable right to human dignity, safety, and freedom from violence and abuse, and sexual and reproductive rights, may be equally important in improving their mental health.

Women’s mental health is eroded by entrenched gender inequality and social beliefs that facilitate structural violence which individuals are powerless to change. In this situation, a model of psychological care or intervention that focuses on causes of distress within the individual is unlikely to alleviate psychological suffering caused by endemic social and political factors within their culture.

The mental health consequences of unjust treatment simply cannot be culturally condoned as an acceptable aspect of culture or tradition or professionally neglected in our collective imagination. This is true whether the injustice involves the violation of women’s right to autonomy and safety or the human rights violations experienced by persons with disabilities, children, or refugees. If a right exists, it must apply universally.

This Cambodian study highlights how the political is in the process of becoming personal, as the public/political discourse of equal rights begins to serve as an internal resource for women’s resistance to violence. The political counter narrative about the illegality of violence against women opens a sphere of rebellion, a way to talk back—even if only in one’s own mind at first. To know that violence is wrong, to imagine new possibilities for gender relations, can be the beginning of change. The study also demonstrates how critical it is to have a shift of perspectives within the cultural discourse that allows a shift within a person’s perception of acceptable gender relations and one’s self-worth.

9.4 Conclusions and Further Recommendations

In congruence with the action agenda proposed by this volume for socially responsible psychology in a global age, we recommend the following considerations for the future teaching, research, and training of psychologists. Our conclusions and recommendations are based on our shared experience in working with issues of oppression, discrimination, and violence against women worldwide.

9.4.1 Developing a Genuinely International and Global Curriculum

Psychologists in the U.S. are often disconnected from direct experiences of cultures that differ from their own, despite the diversity of cultures within the U.S. In order for psychology to become more socially responsible, we need to become less disconnected from the diversity of alternative models of mental health.
Unfortunately, as the consolidation of wealth and power has grown stronger in the West, for example, through corporate globalization, we are witnessing a strengthening of attitudes/values that tend to accompany a weakening of democratic protections and institutions associated with “archetypal” patriarchy—militarism, intolerance, scapegoating of the vulnerable (e.g., immigrants, Muslims), idealization of “strength,” expansion of patriarchal religiosity, and a rise in misogyny. These attitudes are also associated with unreflective, dominating materialist self-interest: a domination of the natural world associated with its destruction (i.e., “drill baby, drill!”), a refusal to address our looming global environmental crisis/catastrophe, an attempted political assault on the rights, status, and health of women, and an increase in blaming those in poverty for their own plight.

9.4.2 Suggestions Addressing Prevailing Values that Foster Individualism

Consistent with the extensive discussion of these issues in Chap.2 of this volume, we argue that there is an urgent need to offset the assumptions within psychology that support and increase self-interest—both personal and political. Political theories that guide many U.S. economic policies are based on a model of the person as a separate individual who is connected to others through economic activity and whose self-interest furthers the larger economic good (e.g., Adam Smith). This emphasis on self-interest as attached to economic prosperity is undergirded by psychology’s regard for self-interest as an indicator of health and positive self-regard. Alternative views, such that we all exist as part of a larger collective and thus share responsibility to care for the Earth and for one another, are sidelined as irrational or “soft.” Economic self-interest has been a driver in the exponential export of anti-depressant medicines throughout the world by U.S. drug companies, supported by DSM diagnoses locating illness within individuals and by psychology’s adoption of the biomedical model of depression (Gordon 2010). Further, models of treatment both within and outside the U.S. carry underlying values that emphasize the rational, verbal, and cognitive domains of functioning that may differ from the client’s cultural orientations—toward affective cues or interpersonal solutions, for example.

Thus, in order to deal with the pervasiveness of oppression and its effects on societies and persons, we contend that a commitment to social justice must be central in psychology’s efforts to develop a socially responsible psychology. It is clear that the oppression of women is inimical to the achievement of development goals and is not sustainable in our world. Gender equality is one of the eight Millennium Development Goals now being pursued internationally with the overarching goal of eradicating poverty by 2015. In the foreword to the latest report on these goals (United Nations 2012), the Director General of the United Nations, Ban Ki Moon observed that the goal of gender equality remains
unfulfilled and causes ‘broad negative consequences, given that achieving the MDGs depends so much on women’s empowerment and equal access by women to education, work, health care and decision-making.’ In other words, without gender equality, all other goals including those which seek to improve the health of women and children and ensure sustainable development (Goal 7) cannot be realised. When women achieve rights, education, and economic freedom, they become agents that can help transform societies.

Psychologists have a vital role to play in developing more models that foster gender equality, models that are not based on individualism or the biomedical model alone, but on the relational self, following assumptions of interconnection and contextual complexity. Psychologists need to be at the forefront of developing treatments and interventions for the linkage between violence, oppression, and psychological distress in our world.

9.4.3 Centrality of Moral Principles in a Global Psychological Action Agenda

To heal means to make whole again; this can only occur at the dynamic interface of the collective and the individual. The self is relational, each person exists as part of a larger whole; healing requires reconnecting people to their sense of worth, significance, and value as part of a whole. To fulfill the aspirational goals of the United Nations Declaration of Human Rights and the Earth Charter, we need ways to increase people’s sense of connection and concerned responsibility for each other and the Earth. How can this occur?

The precepts of the Earth Charter and the UNDHR depend on compassion as well as social justice. Compassion is a form of connection characterized by care, concern, and openheartedness. Studies show that social exclusion undermines a person’s inclination to help or cooperate with others (Twenge et al. 2007). On the other hand, Fredrickson’s (2000) ‘broaden and build’ theory of positive emotions, such as joy, interest, contentment, and love, reveal that such feelings enhance or free-up a person’s prosocial inclinations and behaviors. Research in social psychology has already confirmed that experiencing positive affect increases the likelihood that an individual will help others who are in need (see Mikulincer and Shaver 2005). As Fredrickson (1998, p. 12) notes, “...Altruism... can engender the positive emotion of gratitude in the person who receives help. Experiences of gratitude, in turn, often create the urge to reciprocate and thus form the base for a continuing cooperative relationship” (Oatley and Jenkins 1996). One of the most well-documented ways to increase positive emotions and a ‘readiness to act’ on behalf of others is through training the mind in compassion (Davidson and Begley 2012). Through the Mind and Life Institute’s collaboration between Buddhist monks and Western psychologists, new forms of intervention based on mindfulness and compassion are healing mental suffering in contexts such as prisons, jails, low-income communities, and the
armed forces. Such interventions are used in the treatment of mental distress such as PTSD, depression, eating disorders, addictions, and anxiety, as well as to improve immune functioning and health, more broadly. The explosion of research, new models for interventions, and a basic re-examination of consciousness offer a strong example of the creativity unleashed when Western understandings of health, healing, and connection are enriched by world views and practices that are based on fundamentally different values and perspectives. To move toward a socially responsible psychology for a global age, we would do well to heal the collective through embracing the values of interconnection and co-responsibility for each other and the earth, to collaborate with other cultures and disciplines as we move toward the aspirational goals of the UNHDR and Earth Charter, and to include the “realm of spirit/heart/psyche/soul” as we do our work.

References


