



The mental health gender-gap in urban India: Patterns and narratives

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ABSTRACT

Women report significantly higher levels of mental distress than men in community studies around the world. We provide further evidence on the origins of this mental health gender-gap using data from 789 adults, primarily spousal pairs, from 300 families in Delhi, India. These data were collected between 2001 and 2003. We first confirm that, like in other studies, women report higher levels of mental distress and that gender differences in education, household expenditures and age do not explain the mental health gender-gap. In contrast, women report significantly higher levels of distress than men in families with adverse reproductive outcomes, particularly the death of a child. Controlling for adverse reproductive outcomes sharply reduces the mental health gender-gap. Finally, mental health is strongly correlated with physical health for both men and women, but there is little evidence of a differential response by sex. We complement this empirical description with anthropological analysis based on ethnographic interviews with 100 men and 100 women. With the help of these ethnographic interviews we show how adverse life events for women are experienced as the inability to maintain the domestic, which seems to be at stake within their life worlds. We raise issues for further research on the apparent finding that the mental health of women and men are differentially affected by adverse reproductive events in the family in this sample.

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Introduction

Community and epidemiological studies of mental health consistently find that women report worse mental health scores than men (Davar, 1999; Kessler, 2006; Patel, Araya, de Lima, Ludermir, & Todd, 1999 and World Health Organization, 2009). In addition, the relation between women's mental and reproductive health has received considerable attention in recent years as it has come to be recognized that reproductive health conditions can impose a considerable burden on women's health and lives (Patel, 2005; Patel & Ooman, 1999 and World Health Organization, 2009). While these studies have added to our understanding of the association between socioeconomic conditions and reproductive and mental health, the literature thus far has focused primarily on high-income countries. Thus, the World Health Organization (2009) report on reproductive and mental health emphasizes that most research on the topic comes from Australia, Canada, USA and Europe. In fact, only 10 percent of the studies on the link between

maternal mental health and child health were from low and middle-income countries. Resource poor settings are also research poor settings for mental health issues.

In this paper we study the factors associated with poor mental health among men and women in the low-income setting of Delhi, India. We use the empirical regularity that women report worse mental health scores than men as a lens through which to unpack the specific conditions of women's lives that produce both poor mental health outcomes at the population and individual level. Specifically, we present quantitative and qualitative evidence on the association between women and men's mental health, reproductive events, socioeconomic characteristics and physical morbidity using a long-term study of morbidity and mental health among 300 households, both poor and non-poor, in the city.

This study, carried out by the Institute of Socioeconomic Research on Development and Democracy (ISERDD) between 2001 and 2003, observed 300 households in seven neighborhoods of the city over a 2-year period with an average of 35 observations for every household in the survey. During the course of the survey, ISERDD collected detailed information on socioeconomic characteristics, reproductive events and morbidity in the sampled households. In addition, ISERDD implemented an 80-question module on mental health with 789 adult men and women in the

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same households once during the 2-year period. These data were complemented with 363 open-ended ethnographic interviews conducted by researchers at the institute who were first trained by anthropologists. These data thus present a unique opportunity to construct measures of mental health and illness at a level of detail typically not available in other surveys. The data also present an opportunity to combine methods from empirical economics and anthropological research in ways advanced by Kanbur and Shaffer (2007) and Rao and Ibáñez (2005), whereby the production of quantitative results is understood in terms of the complex community processes and family dynamics that are uncovered through qualitative work. We submit that such a combination presents a step forward in understanding the production of mental health in low-income countries and the identification of fertile areas for future research.

We situate our contribution within three strands of the existing literature. First, the fact that current evidence is skewed in favor of countries with higher standards of medical care and lower risks of maternal and child mortality and maternal morbidity, implies significant gaps in our understanding of the association between reproductive and mental health in resource poor settings. For instance, the WHO (2009) report, states that, “*In developing countries where pregnancy loss of all kinds is more common, it is arguable that miscarriage may be felt as more profound, especially if it represents to the women the loss of her role as mother in a society where alternate roles are limited or nonexistent.*” (WHO, 2009, page 68). Yet, this conjecture remains unsupported by references to any specific research and, as anthropological studies of reproductive failures in families steeped in poverty and high child mortality suggest, the reality may be more complicated. Maternal grief may be mediated by differences in cultural constructions of pregnancy loss and reproductive health (Cecil, 1996; Pinto, 2008; Ramasubban & Singh, 2001). Further, in some contexts mothers may invest more emotional resources in children who are likely to survive, rather than those who are sickly and judged as likely to die (Scheper-Hughes, 1993).

Second, perhaps because of the dominant medical model in public health that treats a woman as an isolable individual and the individual body as a *location* for disease (Foucault, 1973), there is a relative neglect of the texture of familial relations and their impact on mental health. Thus, most studies of the intersection between mental health and reproductive health focus on a limited number of reproductive health conditions (such as pregnancy loss or menopause) treating them as discrete events that impact on the mental health of women (WHO, 2009). In contrast, if we take the life-course as a continuity, we embed the discrete events of reproductive failure in the context of other household events, such as illnesses of other family members and self and declines in the economic conditions of the household (Batra, 2003; Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). As argued by the World Mental Health Report (WHO, 2001) we need to think of mental health not only as a set of symptoms but also as a cluster of adverse conditions and disabilities that ultimately influence the capabilities of men and women to care for themselves and others (Desjarlais, Eisenberg, Good, & Kleinman, 1996). Yet, there may be severe limitations to a purely quantitative approach in understanding these complex inter-linkages. For instance, as Murray and Lopez (1998) argue, dependent co-disability whereby one disability (taking disability in the broad sense of both physical and social disability) increases the likelihood of another is hard to quantify. It seems necessary, then, to expand our methods to include such qualitative methods as the narrative analysis of life stories in order to understand the cluster of conditions within which the relation between poverty, reproductive failures and mental health can be analyzed.

Finally, it is important also to address the unconscious bias that may arise from limiting our questions to the way in which the poor mental health of a woman affects her ability to offer care, treating women as exclusively responsible for care giving in the home, to the neglect of other questions (Boyce, Hickey, & Parker, 1991). We need to ask how women’s own capabilities are affected by the behavior of others, such as male partners or other members of extended families and kinship networks, co-workers, as well as by pressures from the wider society to adhere to strictly defined gender roles (Kittay, 1998). For instance, there is some evidence that the risk of physical violence increases among young women in low-income communities if they find employment suggesting that there might be a backlash against women who might be seen as threatening the authority of men although it is not clear if older women face similar risks (Krishnan et al., 2010). Such a shift of emphasis on relationships rather than individual bodies would also make it imperative to treat mental health of women and men as related and even mutually constitutive. The particular approach we follow, of treating the *household* as the constitutive unit, eliciting information on mental health for both men and women, and complementing the quantitative analysis with qualitative information thus allows us to broaden the discussion beyond the specific link between reproductive outcomes and an individual woman’s mental health.

Our paper is organized as follows. We first detail the sample and study instruments, concluding with a basic description of the data. We then present the quantitative specifications and results and follow the discussion with selected case-material from ethnographic interviews.

Description of study and sample

The sample

In 2001, the Institute of Socio-Economic Research on Democracy and Development (ISERDD) began a longitudinal study of urban households in seven neighborhoods of Delhi, India. Three of the neighborhoods were poor with average monthly household expenditures (in 2002 Indian Rupees with a nominal conversion rate of \$1 = Rs. 49.09) of Rs. 4165, Rs. 4313 and Rs. 4898, two middle income (Rs. 5309 and Rs. 7849) and two relatively wealthy (Rs. 14,892 and Rs. 16,117). These localities were chosen on the basis of initial contacts; once a contact had been established, the sample of households was drawn randomly by asking every alternate household to participate. In all, 300 households were thus selected with less than a 4 percent rejection rate among those approached. These households were observed over a period of 2 years using a mix of weekly and monthly-recall surveys with detailed information on individual health and health-care seeking behavior. In addition, demographic, income and consumption modules were administered three times in the two years and special modules on mental health and reproductive outcomes were administered between the 12th and 24th month of the study. Over the two year period of the study, attrition was less than 5 percent in the sample.

On average, the individuals in the sample are young (with a median age of 22), poorly educated (50 per cent of all individuals are illiterate or have less than primary education) and live in nuclear households with an average of 5.4 members per household. Joint families, as defined in terms of co-residence of married sons (or more infrequently, daughters) and parents in the same household are less frequent: 73 percent of households are “fully” nuclear in the sense that they comprise of a head-of-household, his spouse and children (in 4 percent of these households either the father or the mother of the head is co-resident) and another 24 percent report a married son and daughter-in-law living together with the

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