Probing the Socioeconomic and Cultural Position of Women with Mental Illness in Assam

Berlin Gogoi[1], Gargi Das[2], Gitali Patra[3] and Polly Vauquline[4]

Abstract

Gender is the most prominent social division ingrained through culture and socialization. The intersection of gender and mental health cannot be overlooked. Studies reveal the prevalence of gender discrepancies in the context of mental health and illness. Some mental illnesses are more prevalent in women than men. Women are more likely to suffer from emotional and neurological illnesses such as depression, while men suffer from personality disorders.

The present research looks at the issue of women's mental health from a feminist perspective, as gender is a critical determinant of mental health. This study is based on an exploratory approach from a feminist perspective. Primary data collected from stakeholders, caregivers and women who have recovered from mental health forms the basis of this study.

This research shows that social attitudes and stigmas were indeed associated with the mental illness of women and are influenced by prevalent patriarchal notions and gendered society. Interestingly, their socioeconomic position both within and outside the house has an impact on their mental illness and the treatment thereafter. This study found that a patient's economic status, marital status, family support, upbringing, social attitude and associated stigmas played key roles in their treatment-seeking experiences and well-being.

Introduction

Gender approach to mental health is important because it provides guidance for identifying appropriate responses from the mental healthcare system, as well as

[1] PhD Research Scholar, Department of Women's Studies, Gauhati University.Email: berlingogoi.gu@gmail.com

[2] PhD Research Scholar, Department of Women's Studies, Gauhati University.Email: gargidas@gauhati.ac.in

[3] PhD Research Scholar, Department of Women's Studies Gauhati University. Email: gitali@gauhati.ac.in

[4] Professor, Department of Women's Studies, Gauhati University. Email: pollyvauquline@gauhati.ac.in

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from public policy. Women's mental health affects others in society. Their increasing presence in the workforce means that their mental health affects national productivity (Afifi, 2007). Research also indicates that in adolescence, girls have a higher prevalence of depression and eating disorders, and are more likely to engage in suicidal ideation and self-harm. They try harder than boys, who are more prone to engage in highs, perform risk behaviours and commit suicide more frequently (Parker& Roy, 2001). To look at it in a global context, in 2022, the National Institutes of Health reported that among non-Hispanic Black women, prescription drug overdose deaths are more common among women than men (Perham-Lippman, 2022). In addition, female health workers experienced more depression, insomnia and mental distress during the Covid-19 pandemic (Thibaut & van Wijngaarden-Cremers, 2020, Vauquline, 2021).

Gender is the most prominent social division in grained through culture and socialization. Therefore, mental health is also gendered in nature; the intersection of gender and mental health cannot be overlooked (Anand, 2020). Rosenfield and Mouzon, state that internalizing disorders and externalizing disorders vary among men and women. Women show more internalising disorders such as depression and anxiety but men show more externalizing disorders such as substance abuse and antisocial behaviour, which are problematic for others (Rosenfield & Mouzon, 2012). In their analysis, Rosenfield and Smith emphasize on overriding gender conceptions such as power positions held by men and women and associated differences in responsibilities associated with gender roles and personal characteristics as relevant for mental health (Rosenfield and Smith, 2010). Definitions of masculinity and femininity also impact men and women psychologically by creating gender differences in major risk factors, which, such as differences in the stressors experienced, their coping mechanisms, social relationships, vulnerabilities (Rosenfield & Mouzon, 2013).Hence, women and men are not affected by mental health problems in equal proportions, but by different types of complications. Women primarily experience anxiety and depression, while men are mostly affected by behaviour and personality difficulties, including alcohol and drug dependence (Payne, 1999; Prior, 1999; WHO, 2001a; Brawman-Mintzer, 2002; Busfield, 2002; WHO, 2004, WHO, 2022). According to the World Mental Health Report: Transforming Mental Health for All, 'slightly more women (13.5% or 508 million) than men (12.5% or 462 million) live with a mental disorder, while more than 10% of pregnant women and women who have just given birth experience depression' (WHO, 2022, p. 43). The report further states that,

> *"Women who have experienced intimate partner violence or sexual violence are particularly vulnerable to developing a mental health condition, with significant associations found between victimization and depression, anxiety, stress conditions including PTSD, and suicidal ideation. Women living with a severe mental disorder are much more likely to have experienced domestic and sexual violence during their life than other women." (WHO, 2022, p. 43)*

Furthermore, gender variations are further reflected in their symptoms, treatment and outcomes (WHO, 2001; Kornstein & Clayton, 2002). Therefore, gender is a critical structural determinant of mental health and mental illness that intersects with and deepens the disparities interconnected with important socioeconomic determinants (WHO, 2001). This statement also highlights the importance of other social factors linked to the prevalence of mental health problems. Amongst such factors, disadvantage is the one most clearly associated with the development of mental illness (Prior, 1999; U.S. Surgeon General, 2001; Morrow, 2003; WHO, 2003).

The gender dimensions of mental health issues have also concerned the feminist movement. The basic reason for this is that women's health concerns, particularly, mental health concerns and experiences have often been pathologized. According to Dr. Mindy J. Erchull, it is more likely for women to be called 'crazy' in daily conversations as well as in media and their distinctive life experiences are also marked as 'disordered'. (Fabian, 2017)"

Thus, the adoption of a feminist perspective that encompasses a broader analysis based on the social determinants of health is necessary for the prevention, diagnosis and treatment of mental illness and the promotion of healthy mental health in the population.

Rationale of the Study

Studies show evidence of a strong prevalence of gender discrepancies in the context of mental health and illness (Bhatiya & Goyal, 2020). Some mental illnesses are more prevalent in women than men. For example, women suffer from insomnia more than men by around 40% (Hale, et al., 2009). Besides hormonal variation between men and women, research has found some sociological explanation behind it. Generally, women are involved in some time-consuming work such as child rearing, food preparation, and cleaning. It can affect a woman's sleep (Hale, et al., 2009). Women are also more likely to suffer from emotional and neurological illnesses such as depression, while men are more likely to suffer from personality disorders (Dohrenwend, 1980). For example, in a study conducted in Pakistan to examine 'Gender Difference in the level of Discrimination and Stigma' experienced by people diagnosed with Major Depressive Disorder found that a high level of associated stigma and discrimination with their mental illness is experienced both by men and women. But women experience significantly greater levels of internalized stigma in spheres of discrimination experience and social withdrawal (Khan, N., Kausar, R., Khalid, A., & Farooq, A. 2015).

Socio-cultural models suggest the significance of socio-cultural factors on mental health in a range of ways. Research into different socio-demographic factors from a gendered lens have found that in understanding the exact determinants of how gender effects on mental health is still lacking (Bhatia & Goyal, 2020). For, example, being

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single and unemployed had a direct connection to an increased rate of mental disorders in men than in women (Bhatia & Goyal, 2020; Klose & Jacobi, 2004).

But other studies have failed to find any difference between the sexes (Schwartz 1991; Dohrenwend & Dohrenwend 1976). In relation to mental illness, one finds that a lot of prejudice has accumulated in the minds of people far more than other forms of physical illness. People with mental illness across countries, societies and cultures are discredited and devalued compared to people without mental illness (Rössler, 2016).

For a long period, women have been over-represented in prevalence studies of mental health problems (Prior, 1999). This situation has been attributed to historical views of women as inherently irrational and mentally weak (Prior, 1997). Women are always considered to be twice as likely as men to be depressed or suffer from anxiety disorders and the reason for this disparity in mental illness is unclear and is linked to biology, unique personality characteristics, and a lack of control in society (Fredrickson & Roberts, 1997).

The concerns for women's mental health also extend beyond specific conditions or problems. They encompass the structures that govern the provision of health-related education, information and health care delivery, the processes that influence women.

Today, an accurate need for assessment of women's mental health, remains vulnerable due to inadequate sources of data, an overly biological and individual focus in research as well as theoretical models which often neglect to consider – how women's low social status and material circumstances intersect with their family roles and their participation in paid employment. All of these play a critical role in determining mental health outcomes. And the omission of these social factors from studies of women's 'vulnerability' to mental health problems, amounts to a form of selection bias which precludes the possibility of examining how gender inequalities might determine women's emotional well-being. Here, the argument is in the context of gender, it is a term that refers to the socially constructed understanding of what the male and female characterizes (Vauquline, 2021).

The advocates of the sociological perspective forward the opinion that biological and psychological characteristics of the human subjects are not the sole determinants of their mental health; structural features which determine role and status of members of a society, shape their behaviour and influence the logic of resource allocation, thereby privileging some members of the society to the detriment of others (Vauquline, 2015).

Socio-cultural perspectives are important because people grow up and live within larger scale social organizations. Different types of institutions affect their socialization process. These institutions include family, school, city, state and many more. The surroundings of people, the institutions, and communities related to these institutions shape people's language, their belief system, values etc (Lemke, 2001; Vauquline,

2015). Therefore, the impacts of these institutions may vary within and between cultures from person to person. And the definition of mental health can change over time. Therefore, it is important to study about the socio-cultural determinants such as gender, race, ethnicity, etc. which may contribute to the mental health of a person. People's cultural background affects their mental health. Family, religion, social norms, etc. play a role in shaping a person's mental health and these factors affect each person's mental health differently (Brands, 2022). Gendered socio-cultural obstacles may prevent women from gaining a better treatment for mental health.

Socio cultural factors contribute to gender differences in health and mental health. Attributes and experiences of men and women are different including some variables such as sex roles, social support, social isolation, marital status, educational status etc. The demographic burden of men and women are different. For example, regarding poverty, unemployment, and care-giving responsibilities, the experiences of men and women are different (Shear, Halmi, Widiger, && Boyce, 2007). Structural gender inequality limits access to health services for girls and women and contributes to health inequality (Barr & Temkin, 2022).

Likewise, the stigma and discrimination associated with mental health are also different for different genders. Within the field of mental health, the notion of stigma which denotes relations of shame and nonconformity from the 'normal', has been ongoing for a long time. There have been different approaches to the notion of stigma which ranges from a 'social psychological emphasis on prejudice to structural critiques, emphasizing a social disability model' (Rogers & Pilgrim, 2021, p. 232). It is a culturally enduring phenomena which has existed through times and regions maintained consistently through social structures and cultural variations and through individual responses to what is considered deviant behaviour (Rogers & Pilgrim, 2021).

Historically, the mentally ill have always been stigmatised and the word also carries a negative implication (Rössler, 2016). The word 'stigma' is derived from the Greek practice of marking bodies of individuals who supposedly have unusual or bad moral conduct through cuts or burns, to advertise someone who should be avoided. However, today, stigma has become an attribute, behaviour or reputation which is socially discredited and disapproved (Bos et al., 2013; Crossman, 2018; Goffman, 1963; Rössler, 2016). Society never treated people experiencing mental illness such as depression, autism, schizophrenia, etc. any differently from criminals. They would also receive imprisonment, torture or death. During Middle Ages, they were thought to be punished by God or to be possessed by the devil. They were burnt at the stakes or chined to bed in the madhouses (Rössler, 2016). Even today the general population is largely ignorant to the problem of stigmatisation faced by the mentally ill. This is an important social problem which still exist and is unavoidable.

Structural discrimination of the mentally ill is still prevalent, in legislation as well as in rehabilitation efforts (Rössler, 2016). Stigmatisation promotes social differences leading

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to "spoiled social identity" (Goffman, 1963) and it occurs through social interactions (Bos et al., 2013). This implies that stigma does not exist on the body but on the social context meaning stigmatisation may differ depending on the social situation and function as a tool for exercising power through exploitation and dominance (Bos et al., 2013). It can also function as a tool for exercising social norms to prevent deviant behaviour and for disease avoidance (Bos et al., 2013). Consequently, stigmatisation of mental illness can be a barrier for health seeking behaviour among women with mental illness. Also, due to culturally constructed behaviour norms for women through gender roles and negative attitudes, the perceived stigma towards women with mental illness is higher. As stated by Bhatiya and Goyal (2020), "The fear as well as experience of stigma in case of women therefore often leads to non-disclosure of their psychiatric illnesses, and shying away from treatment facilities; thus, potentially leading to poorer outcomes as compared to men with psychiatric disorders" (Bhatiya & Goyal, 2020, p. 55).

In this regard the present research seeks to look at the issue of women's mental health from a feminist perspective. Mental illness among women needs to be understood in the context of a myriad of realities.

Mental health can be threatened by factors other than biological and psychological. Social factors certainly affect the mental health of women, and undermining the role of the same would amount to delegitimization of women's experiences and their voices (Davar, 1999). As Bhatiya and Goyal point out,

> *"The origins of much of the pain and suffering particular to women can be often traced to the social circumstances of lives of women. Socialized to be submissive, tolerant and timid, women often undergo bouts of depression, hopelessness, exhaustion, anger and fear, are overworked, face domestic and civil violence, entrapment and economic dependence." (Bhatia & Goyal, 2020, p. 50)*

Objectives of the Study

The following objectives are taken for the study

1. To study the societal attitudes and stigma associated with women's mental health.
2. To probe the role of socioeconomic and cultural factors associated with women's mental health.

Research Questions

1. What affect women with mental illness more, social attitudes', stigmas and taboos or her socioeconomic and cultural positions?

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Database and Methodology

The study used exploratory approach to probe the problem from feminist perspective. In-depth understanding of issues revolving around mental health through gender lenses is very challenging because of the challenges imposed in the data collection process. Thereby, through exploratory research the researchers made an in-depth investigation of the research questions not studied previously (Singh, 2021). Exploratory research aims at applying new words, concepts, explanations, theories and hypotheses to reality with the expectation of offering new ways of seeing and perceiving how this segment of reality works, how it is organized, or more specifically how and in what ways different factors relate to each other (Reiter, 2017).

Or non-exploratory research may reflect what is already known and there is a risk of repetition of the results (Swedberg, 2020). Grounded Theory supported and shaped the methodology. Grounded theory generates or discovers new theory from the data in social science research rather than forcing data into a few existing theories (Urquhart, 2022). Through Grounded Theory the researches tried to explain how mental illness was stigmatised by the social relationships and social behaviours of the care providers with women with mental illness (Noble & Mitchell, 2016). The study went deeper to relate these behaviours with gender and understand them from feminist perspectives.

Database

Primary Data

There is evidence of a wide range of barriers in conducting interviews and processing information attached to mental illness/ health. To overcome these barriers data triangulation was applied for this study. As such data were collected from the stakeholders, caregivers and female patients as well as researcher's observation will be taken into consideration to understand the stigmas and social attitudes attached with mental illness.

I. Stakeholders included Psychiatrist, Psychiatric Nurses, Psychiatric Social Worker and Counsellors. Interviews of these stakeholders were conducted to get insights of those participants who were not in a position to interact efficiently on their own because of their mental state. This was particularly common in the case of participants from Ashadeep.

II. Caregivers included parents, nearest relatives, spouses and children who were interviewed to understand the social factors and medical assistance seeking behaviour associated with mental health of women.

III. Female patients who have undergoing treatment and were mentally fit to respond to the questions asked.

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Data Collection Period

Data was collected from in-depth field interviews and a combination of participant observation by using the qualitative methodology and quantitative method wherever necessary. It was conducted from October, 2019 to March, 2020 at LGBRIMH, Tezpur, Sonitpur. And again, from April, 2022 to May, 2022 both at Ashadeep –a Mental Health Society, Bamunigaon, Kamrup (Rural) and in LGBRIMH, Tezpur.

Secondary Data

Materials were collected from different e-books, articles, journals and books by visiting Gauhati University and organizations like SNEHA (Mumbai), and Ashadeep a Mental Health Society.

Sample Size

The care- givers of the 23 female patients that is 23 care- givers staying in LGBRIMH, Tezpur were interviewed. For the female patients at Ashadeep their caregivers those who were also the stakeholders were consulted for taking their interviews. At least 31 key individual interviews with the stakeholders including psychiatrist, psychiatrist nurses, psychiatric social workers, and counsellors were taken which included from both the organizations for the study. Additionally, in order to make the interviews more efficient, interviews were conducted in those languages which the participants felt comfortable to communicate such as Hindi, Bengali, English, and Assamese

Selection of the Sample

The sample taken for the study was purposive and based on accessibility as well as willingness of the participants to be part of the study. Permissions from the consulting psychiatrist were taken prior to selecting interviewees, particularly of those women who have recovered from mental illness. The stakeholders were the mental health professionals who were working in the institute and caregivers selected for the study were the corresponding guardians of the women patients admitted in Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, (Tezpur, Assam) and Ashadeep, which is a Mental Health Society at Bamunigaon, Kamrup (Rural), Assam.

Tools

Quantitative and qualitative semi - structured interview schedules were used to understand the experiences, actions, views and attitudes of the female patients, caregivers and stakeholders of the study.

Different Sets of Questionnaires were Prepared

i. For stakeholders.

ii. The Care- Givers/Providers of the participants.

iii. Female patients

In this research, the main sources of data are qualitative in nature collected from the semi- structured interviews. The research does not intend to generalize the whole population but instead explore in-depth the problem and spend a sizable amount of time with a small population (Krueger, 1988; 1994; 1998; Krueger and Casey, 2000; Wimmer & Dominick, 1997).

Quantitative Data

The quantitative data was collected from the Out Patient Department (OPD) of LGBRIMH, Tezpur for one of the objectives of the study. In order to find the total number of female and male patients in the OPD and Indoor wards of the organization for the last 10 years from 2011 to 2021 as part of the study.

Audio recorder was used for the study as the importance of recording in-depth interviews is well established (Longhurst, 2003; Valentine, 1997). It was ensured that permission was granted by the interviewee for the same. The interviews conducted other than English, were translated simultaneously while preparing the transcripts.

Ethical Considerations

Ethics approval was obtained from the Institutional Ethics Committee, Gauhati University GUIEC/2019/017 and from Institutional Ethics Committee IEC No: 378 of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH). All the participants were informed about the purpose of the study, measures were taken to ensure confidentiality and that their participation was voluntary, they would withdraw at any time. Informed written and verbal consent was provided by all participants.

Feminist Perspective

There is an overwhelming recognition that the feminist approach has brought substantial gains to the development of social research through the positive and creative production of knowledge and should not be undermined (Ramazanoglu, 1992).

Feminist practices favour qualitative techniques because they reflect on the complexity of women's lives. Qualitative techniques allow the researcher to investigate the feelings, knowledge and understandings of the participants through in-depth interviews, focus groups and participant observation in order to gain an intense and deep understanding of the processes shaping the social world (Dwyer & Limb, 2001).

There are different opinions from feminists which vary with respect to epistemology and research methodology, a strong consensus exists that feminist research should

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be largely qualitative, action-oriented and alert to women's experiences. Therefore, this study looking into the gender perspectives of the social attitudes and stigmas associated with mental health inherently benefits from feminist research approaches.

Grounded Theory

For this study, grounded theory was used as it begins with the area of study rather than beginning with a theory and later on probing it. Grounded theory can be described as a general and systematic research method usually associated with qualitative methodology. Originally formulated by Barney Glaser and Anslem Strauss, this method aims at a generation of a general theory (Strauss, 1987; Strauss and Corbin, 1990; Strauss and Corbin, 1994; Strauss and Corbin, 1997).

The main objective of this method is –

> *"To build a theory which is faithful and illuminates the area under study but data collection, analysis and theory stand in reciprocal relationship with each other. One does not begin with a theory, and then prove it. Rather, one begins with an area of study and what is relevant to that area is allowed to emerge." (Strauss and Corbin, 1990: 23, 24)*

Grounded theory begins with a research situation and follows an inductive approach that acknowledges the researcher's role developing and provisionally verifying a theoretical account of the general features of a topic while simultaneously grounding the account in empirical observations or data (Martin and Turner, 1986).

Through Grounded Theory the researcher, tried to explain how mental illness was stigmatized by the social relationships and social behaviours of the care providers with women with mental illness. The study went deeper to relate these behaviours with gender and understand them from feminist perspectives.

Universe of the Study

Universe of the study consists of all the women from the age group of 18 years and above who are residing or associated with the two institutes taken for the study.

The institutions selected were:

- - Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Assam and
- - Ashadeep, which is a Mental Health Society at Bamunigaon, Kamrup (Rural), Assam.

The former is the Government Mental Health Institute in the entire North East India that cater to the needs of the people of entire north eastern part of India at an affordable

price and the latter is the only non-government sector dedicatedly working for the causes of mental health in the state of Assam.

Findings

From the in-depth interviews with the participants viz. sampled patients, their care-givers and the stakeholders (service providers) along with the researcher's observations were used as a tool for the study. From the transcriptions of the interviews that were audio-tapped with the consent of the participants by the researcher and later on, after the transcriptions the analysis of the data collected was formed into sub themes for the study. The sub- themes found in the analysis were gender gap in treatment seeking behaviour of the patients, economic position an issue of concern for mental illness and marriage as a concern for mental illness.

Gender gap in treatment seeking behaviour can be seen - in respect of total number of male and patients in the OPD and Indoor wards. The number of male patients was higher than the female patients in last 10 years from 2011 to 2021. Another major finding that emerged from the narratives of the participants was the economic position of the male member in the family that affects their medical treatments during mental illness. The narratives revealed that the specific roles that are assigned to men in agrarian based activities in rural area affect their institutional treatment during mental illness. It was - found that women requiring more supportive care in institutional treatment acted as deterrent in their treatment process.

The economic position of women also determined the support received for their mental illness treatment and therefore travelling long distance acted as barrier to seeking mental health treatment. The gendered socialization process affects the treatment of the women as the importance is given to the treatment of men not only in case of mental illness but also in case of other physical illnesses. Another aspect is that marriages of women with mental illness are more complex than men and often people live with the false assumption that marriage can heal mental illness.

Disparity in Treatment Seeking Behaviour of the Patients on the Basis of the Gender

To have an insight about the pattern of treatment received by the patient with mental illness, in both Outdoor Patient Department (OPD) and Indoor Patient Department (OPD) at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur were collected. While collecting the data from the records of the institute from 2011 to 2021, effort was made to segregate the data on the basis of gender. Data of male and female patients were only found in the records. It was observed that there were no mechanisms in the data record system of the institute to collect information of the queer gender. Thereby the data does not provide any information of the queer gender.

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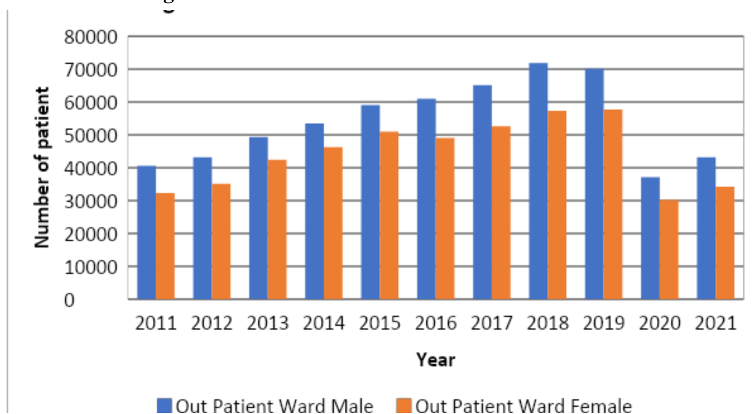
Trend and Pattern of Outdoor Patient Department (OPD) Seeking Treatment on the Basis of Gender

The total number of patients seeking treatment in Outdoor Patient Department (OPD) in Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), during the study period was 1082244 of which 593936 were male and 488281 females, accounting to 54.88% and 45.11% respectively.

Fig 1 provides the trend of male and female patients seeking treatment as outdoor patients. It is very clear from Figure 1 that the proportion of male patients seeking treatment was always higher that the female patients during the entire study period. There was a constant rise in the proportion of patients seeking treatment, both male and female, from the year 2011 to 2019. There is a sudden fall from 70160 in 2019 to 37093 in 2020 of the number of male patients and 57721 in 2019 to 30166 of female patients (refer Table 1). It again shows a gradual increase in 2021. This can be attributed to the impacts of COVID 19 pandemic and a series of lockdowns. However, it is interesting to note that the proportion of male seeking treatment were - higher than female patients even during the Coivid 19 period. This shows that there is no change in attitude towards treatment seeking behaviour among males and females even when pandemic situation hit the country and reported cases of mental illness among men and women also escalated.

Figure 1: Outdoor Patients on the basis of Gender



Source: Data collected from the field by the researcher

Table 1 illustrates the total number of female and male patients enrolled in the outdoor wards of the hospital, at Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur as shown in the Table 6.1 below, highlights the gap in mental treatment seeking between men and women.

Table 1- Total Number of Male and Female Patients in the Outdoor Patient Department (OPD) from 2011 to 2021.

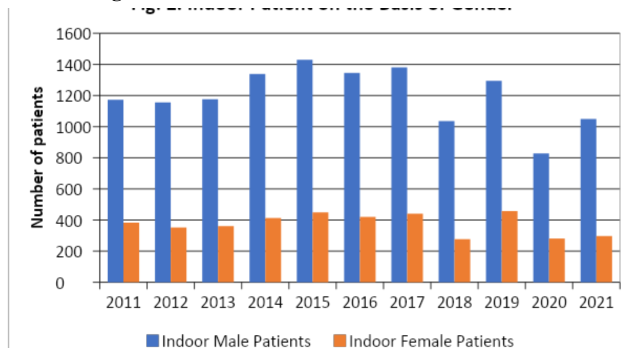
Year	Outdoor Patient Ward Male	Outdoor Patient Ward Female	Total	Male %	Female %
2011	40545	32288	72833	55.7	44.3
2012	43148	35147	78322	55.1	44.9
2013	49300	42443	91743	53.7	46.3
2014	53457	46250	99707	53.6	46.4
2015	59070	51017	110087	53.7	46.3
2016	61013	49090	110103	55.4	44.6
2017	65127	52578	117705	55.3	44.7
2018	71817	57345	129162	55.6	44.4
2019	70160	57721	127881	54.9	45.1
2020	37093	30166	67259	55.1	44.9
2021	43206	34236	77442	55.8	44.2

Source: Data collected from the field by the researcher

6.1.2: Trend and Pattern of Indoor Patient Admitted on the Basis of Gender:

An interesting pattern emerges when we analyse the data of indoor patients on the basis of gender. It clearly illustrates that the gender gaps are substantially high among indoor patients, male patient being on the higher side than female patients throughout the study period.

Figure 2: Indoor Patient on the Basis of Gender



Source: Data collected from the field by the researcher

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Table 2-Total Number of Male and Female Patients in the Indoor Wards, 2011 - 2021.

Year	Indoor Male Patients	Indoor Female Patients	Total	Male%	Female%	Variation (Male & female) (%)
2011	1172	383	1555	75.4	24.6	50.8
2012	1156	352	1508	76.7	23.3	53.4
2013	1176	361	1537	76.5	23.5	53
2014	1338	413	1751	76.4	23.6	52.8
2015	1430	449	1879	76.1	23.9	52.2
2016	1345	420	1765	76.2	23.8	52.4
2017	1381	440	1821	75.8	24.2	51.6
2018	1036	277	1313	78.9	21.1	57.8
2019	1294	457	1751	73.9	26.1	47.8
2020	827	281	1108	74.6	25.4	49.2
2021	1049	297	1346	77.9	22.1	55.8

Source: Data collected from the field by the researcher

Total number of patients admitted during the study period was 17,334 of which 13204 were male and 4130 were female accounting to 76.17 % and 23.82 % respectively. The trend of admitted patients is undulated and not uniform. The disparity of patients admitted on the basis of gender was always above 50%, which is an issue of concern. It was only during the Covid 19 period, that number of female patients admitted in inpatient department increased marginally.. One of the reasons for this was the non availability of paid care givers for home seated mental patients and also difficulty in during the Covid 19 period which left families with no other options than hospitalization.

Socio-Cultural and Economic Factors Associated with Gender and Mental Health

The above analysis clearly illustrated that gender disparities exist in seeking or receiving medical treatment in respect of patients with mental illness. The study also sought to probe the reasons for such divides. To probe deeper into this matter the narratives of the interviews which were taken were explored through gender lenses and thermalized accordingly.

Economic Position of the Male Member in the Family Affects Their Treatments During Mental Illness

One of the major findings that emerged from the narratives of the participants was the dependence of the family members on the adult male members of the family, especially when he is the main income earner of the family. The position of the male member in the family as the main or at times the sole economic earner of the family affected immensely the type and quality of medical treatment he received during his

mental illness. When the main earner of the family falls sick or is suffering from any kind of physical illness or mental illness; his treatment assumes priority and medical treatment is sought or provided. There are urgencies among the family members to get him cured as soon as possible. The family members are eager to look after that person and take care of him; as they are dependent upon him for their basic sustenance.

> *'The priority is the man as he is the breadwinner of the family. They are the farmers. If they do not cultivate what will their families eat for survival? Male being active is very important in an agrarian society,'*
>
> *(Stakeholder – Professor, and Head of the Department of Psychiatric Social Work, 57 years, Female, LGBRIMH, Tezpur)*

Another male Clinical Psychologist from LGBRIMH, narrated.

> *"Male being the only bread earner of the family is the primary reason for getting more importance than a female…'*
>
> *(Stakeholder – Clinical Psychologist, 31 years, male, LGBRIMH, Tezpur)*

The family members have a different perception when women and men suffer from mental illness. Because of the economic position of the men within the family their attitude towards mental illness is also gendered.

> *'I think when a woman is sick the preoccupation with the sickness is not much. But when a man is sick the whole house is sick; I think there is a different perception that people have."*
>
> *(Stakeholder – Senior Faculty of the Department, Psychiatric Social Work, 57 years, female, LGBRIMH, Tezpur)*

Specific Role Assigned to Men and Women in Agrarian Based Activities in Rural Area Affects Their Institutional Treatment During Mental Illness

Not just being the major earner in the family affects the treatment received by male but also the type of socio-economic activities assigned according to the gender has an impact on the treatment received. It is observed that there exists gender division of labour in paddy cultivation in Assam and there are different taboos associated with it. It is considered inauspicious for a woman to plough the field or even touch it. Again, transplanting of paddy is done mostly by women, but if required men also take part. This gender division of labour and the taboo attached makes women more vulnerable as a patient of mental illness.

This is clearly pointed out by a female Professor working in LGBRIMH, Tezpur.

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'…if a woman is sick somehow the system works, I think even at home…'

Again, Professor and Head of the Department, Psychiatric Social Work stated that,

'If the man is not there to plough in the fields along with the bullocks it is not possible to do the farming.'

(Stakeholder- Senior Faculty of the Department, Psychiatric Social Work, 57 years, LGBRIMH, Tezpur)

Women Requiring More Supportive Care in Institutional Treatment Acts as Deterrent in Her Treatment Process

Mental illness treatment requires the support and care from the family and relatives. In case of men, with mental illness, more so if he is the primary earner, this support and care is readily available from the family that is dependent on him. But, in case of women who are dependent, such care requirements may become a liability and therefore, a deterrent to her treatment. She might instead be taught to cope and adjust. One of the stakeholders narrates that:

'Again, management is different between males and females. Females require more supportive care even after they go back to that environment (Home). When we treat them here, we follow up everything.'

(Stakeholder- Senior Resident in the Department of Psychiatry, 29 years, Female, LGBRIMH, Tezpur)

'We have to make sure that she is comfortable in that environment and that her stress factors have been identified and dealt with.'

(Stakeholder- Senior Resident in the Department of Psychiatry, 29 years, Female, LGBRIMH, Tezpur)

'Even if the male is not well for two to three days, they will bring them here immediately. But the women are often subdued.'

(Stakeholder- Senior Resident in the Department of Psychiatry, 29 years, Female, LGBRIMH, Tezpur)

Women's Economic Position Determines the Support for Her Mental Illness Treatment

During the study it was observed that, if the women suffering from mental illness were earning an income, the attitude of the family changed towards her and her treatment was received a priority. One of the stakeholders pointed out that it is not the gender

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but the earning ability that matters.

> *"I think it is all about money. It depends on the source of income. Generally, the male is the breadwinner and the woman is always considered to be the homemaker. I think once a woman starts earning, she is doing both housework as well as earning, then the family attitude changes. This I can say as I have come across such cases. When the matter of income source comes in the family, concern for the patient is also seen."*
>
> *(Stakeholder – Occupational Therapist, 36 years, Female LGBRIMH, Tezpur)*

Gendered Socialization Process Affects the Treatment of the Women

A senior physician of the Department of Psychiatric Social Work, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur, describes that the problem lies in the patriarchal mindset or attitude towards women and the treatment during mental illness. Importance is given to the treatment of men not only in case of mental illness but also in case of other physical illnesses.

> *"Men are given more importance in the family… If a woman complains and says, 'I am not feeling well', 'I am having cramps in the body' – then the response is generally – 'It's okay, you will feel better, take some rest'. But for men it is different. It is the problem of the mindset."*
>
> *(Stakeholder – Senior Faculty of the Department of Psychiatric Social Work, 41 years, Male, LGBRIMH, Tezpur)*
>
> *'Sometimes in case of depression and neurotic illness, the patient suffers, but family members are not bothered because she is doing her work. In that way neurotic cases come very late…'.*

Marriage as a Cause of Concern for Women with Mental Illness

Marriage as a social institution is important across human society. In India, it is generally believed that women married to men with mental illness are more likely to suffer rather than men who are married to mentally ill women (Srivastava, 2013). Furthermore, married women who are mentally ill often get abandoned by their husband and his family and are compelled to return to their parents' home. This further complicates their mental health situation due to facing stigma and ridicule (Nambi 2005; Sharma et al, 2013). On the contrary, women married to mentally ill men often remain trapped with their husbands as they lack support from their own families and face difficulties due to economic dependency, financial, personal and social security and most importantly, for the wellbeing of their children (Srivastava, 2013).

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Marriages of Women with Mental Illness is More Stigmatised than Men

The participants have especially mentioned about the relation of marriages and mental illness. There are different issues associated with marriage which are gendered. Women with mental illness face more discrimination in comparison to men. This can be understood by the narrative of the care- givers of the women suffering from mental illness and the stakeholders who are the service providers

'If a male is psychotic, he can definitely marry but if a female is psychotic then there will definitely be issues in marriage.'

'Due to the stigmas attached with mental illness many unmarried girls are treated in private hospitals.

'Marriage is an important issue for women. Families are more concerned about unmarried women than married women. When a female patient comes for treatment along with her father, the common question that we are asked, – "Can my daughter get married?"'

'For men it is not a big issue. He can have an affair. Even if he is undergoing treatment, he can get married.'

(Stakeholder – Senior Faculty of the Department of Psychiatric Social Work, 41 years, Male, LGBRIMH, Tezpur)

Parents are stigmatised for disclosing about the mental illness of the daughter to her in-laws fearing the breaking of the engagement. It was observed that the parents were more concerned about the daughter's marriage than the daughter herself.

People Live With False Assumption that Marriage Can Heal Mental Illness

The study observed that a common belief upheld among the families of the patients is that marriage can be a solution to mental illness. As stated by a Psychiatrist, LGBRIMH, Tezpur, most guardians of female patients believe that if their daughters get married, they will become well. In fact, when they come for consultation, their primary concern is whether their daughters could get married.

'We have come across many female patients who have not come for treatment although they were suffering from mental illness for many years. Their guardians think that once they get married, they will recover from the illness.'

(Stakeholder – Psychiatrist, 32 years, Female, LGBRIMH, Tezpur)

Similarly, it was also evident that some people believed that late marriage could result

in mental illness among unmarried women and marriage could heal her.

> *"We stay in a village and here people are not educated to understand the causes of her illness. Even my aunt once told me to get my daughter married. She was misbehaving at home (because of her mental illness). My aunty felt that it was because her peers were already married.'*
>
> *(Caregiver – Mother of female patient, 34 years, LGBRIMH, Tezpur)*

Few of the female participants who have recovered mentioned that they were sent back to their maternal homes when they were suffering from mental illness. A few of these women stated that their husbands did not take much care of them during their illness. On the other hand, during the interview with the care providers, family members (in-laws) of the married women stated that they would file divorce once discharged from the hospital. They are not willing to take care and responsibilities of women suffering from mental illness.

Discussion

This study focused on understanding the gender disparities in social stigma and attitude associated with mental illness in Assam. As patients from all over the North East come for treatment in these institutions taken for the study, it provided an opportunity to understand the status of mental health illness and treatment seeking behaviour. Gender variations are further reflected in their symptoms, treatment and outcomes (WHO, 2001; Kornstein & Clayton, 2002), particularly in the case of treatment seeking behaviour and support mechanisms available from the patient's family and society.

In a patriarchal society, more emphasis is placed on the treatment of men than on the treatment of women's mental illnesses, as man is considered the bread earner of the family. This resonates with the patriarchal notions of gender roles prevalent in society which depict men as the independent and dominant and women as dependent and submissive. Our study shows that the number of women admitted to psychiatric hospitals is significantly lower than that of men (Table 1 and Table 2). The percentage of males admitted in both out patient department (OPD) and indoor ward are significantly higher than the number of females admitted, despite the fact that the treatment in these institutes is free of cost. Thus, gender disparity is observed in mental health treatment seeking behaviour. Women in general, are seen to delay treatment or forgo full treatments depending on their economic standing in the family.

The study revealed how socioeconomic factors such as the economic position of a person, be it man or women, affects their treatment of mental illness. It has been observed that families may not agree to spend unnecessarily on a woman's treatment. Furthermore, sending the women to a far-off place for treatment may also be a cause of concern as it will also require the guardian or caregiver to travel along. This affects

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the economic and financial health of the family. This is truer for married women with mental illness whose husband and marital family may not want to invest their time, energy and finances. Such a woman becomes a liability and may also be divorced or abandoned (Nambi 2005; Sharma et al, 2013).

The woman's treatment is given importance only if her economic position in her family is strong and sound. If a woman is an earner in the family, there is a difference in the attitude of the family towards her. Her treatment is given a priority. Gender seems to become relevant with the economic position of an individual. In this context, stigma towards mental health seems to be a myth rather than reality. Stigma is overruled by socioeconomic position of those with mental illness which is why male patients get more preference due to their stronger economic background.

Gendered socialization processes also affect the treatment of women. Afterall, it depends on how families and communities perceive, interpret and control gender roles. This study shows that the stigma attached to women and the importance given to men affects the treatment of not only mental illness but also any illness. This also affects the marital status of women with mental illness.

The acceptance a married woman with mental illness in a patriarchal society is very different from that of a married man with a mental illness. A woman suffering from mental illness is often abandoned by her husband and family and are compelled to return to their parents' home. In contrast, women married to men with mental illness are often compelled to spend their lives with their husbands due to lack of support from their parental families and face myriads of challenges in respect of financial and economic security, personal and social safety and, most importantly, the well-being of their children (Srivastava, 2013).

The present study also revealed that there are many misconceptions about marriage and the cure of mental illness. Many assume that marriage can heal mental illness. Through the interactions with the participants, it was evident that many families trivialize mental illness as misbehaviour or as an upbringing issue and suggest marriage as a solution. Even when they seek treatment, they emphasize on whether their daughters could be married or not. On the contrary, certain families would avoid bringing their female members to psychiatric facilities for fear of stigma and discrimination attached to mental illness, which might create impediments in getting married. Many a times women with mental illness prefer not to get married but society ostracizes them as 'not normal'. This might have adverse effects on their illness and lead to an obsession with marriage. This view might also be related to the patriarchal gender norms which asserts that women's primary role is that of a good wife and mother..

Conclusion

Social attitudes and stigma are indeed associated with mental illness of women and it is influenced by prevalent patriarchal notions. However, the socioeconomic background of the mentally ill and their earning capacity plays an important role in how they are treated. Often it is the socioeconomic position which has a determining role in stigmatising a person with mental illness. Even within socioeconomic position, there is a subtle gendered division where males with higher standing stand to be more privileged in getting treatment for their mental illness vis-a-vis women who have similar or lower socioeconomic standing. Mental health is an important social issue which therefore requires greater emphasis on understanding with a gender lens. The differential experiences by men and women is visible in their symptoms, treatment, outcomes as well as associated stigma and discrimination. This further impacts the overcoming of the illness among the patients. In the case of women, mental health is interrelated to various social factors as well as clinical factors. Their economic dependence or independence, their marital status, their identities within their families and communities, their socialization and upbringing all factor into their mental health and wellbeing.

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