# Mental Health, Gender and Society: The Social-Epidemiological Connect

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**Abstract**

*The term mental health is not merely reflective of the absence of psychopathologies, rather is suggestive of the general state of mind that conduces overall emotional well-being of an individual. The discourse on Mental Health has been addressed by different schools of thought, each having forwarded their premise in contradiction to that of the other. This paper attempts to study the issue from the sociological perspective, while emphasizing on the interplay of different perspectives - whether sociological, biological or psychological - in addressing the issue in a holistic manner. The argument mooted here is that a disturbance of mental health is not caused only by biological and psychological characteristics of human beings but also by structural features which impacts the role, status, behaviour and resources privileging some members of the society to the detriment of others. An insistence on genetic and psychological factors in accounting for mental disorder is rather myopic, due recognition has to be accorded to social dynamics in explaining mental health and illness. An important aspect of this paper is to focus upon how mental health bears differential implications for the female members of the society. This paper is therefore an attempt to contextualize the discussion on mental health with regard to women and their social environment which, as the paper argues, lends itself substantially in influencing their mental health in an unfavourable manner.*

## I. Introduction

A layman's cogitation on mental health would reflect upon as the absence of psychopathologies, such as depression and anxiety. However, mental health connotes the general state of mind that conduces rational thinking, effective communication, learning, emotional development, resilience and a sense of self-worth. To gain a comprehensive insight into what mental health is one can refer to the World Health Organization's definition of mental health: "A state of complete physical, mental and

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social well-being and not merely the absence of disease which refers to myriad activities directly or indirectly related to the mental well-being of an individual. Mental health may broadly be defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 1948: 100).

Mental Health has been addressed by different schools of thought, each having posited their premise in contradiction to that of the other. This paper attempts to study the issue from the sociological perspective, while emphasizing on the interplay of different perspectives -whether sociological, biological or psychological - in addressing the issue in a holistic manner. Another aspect that merits mention in approaching the issue of mental health is how the same bears differential implications for the male and the female members of the society. This paper is also an attempt to contextualise the issue with regard to women and their social ambient which, as the paper argues, appertains to influencing their mental health in an unfavourable manner. The central idea here is to establish the relationship between socially affected factors and illness, physical and mental - in other words the social epidemiological connect.

## II. Data for the Paper

This paper generates data from a household survey, interviews with the key informants (health practitioners, traditional healers, community representatives) and Focus group discussions (FGDs) at community level (SHGs, panchayat office, temples/mosques/churches.

The field survey interacted with 830 women in same number of households in 100 villages of 10 districts of Assam (viz. Sonitpur, Darrang, Dibrugarh, Jorhat, Golaghat, Bongaigaon, Tinsukia, Cachar, Sibsagar and Kamrup) during 2014-15. The data captures the causes of mental illness of the women, impact of religious practices in shaping their attitude and thought process, experiences in natal and in-laws house, income level and difficulties in running the households and opinion on poverty and its consequences.

## III. Mental Health – an Understanding from Myriad Perspectives

For long the discourse on mental health and illness was dominated by the bio-medical paradigm. The etiological accounts cultivated by this paradigm deduced mental disorders as brain diseases and therefore sought 'somatic therapies' intended to address the deep rooted 'biological dysfunctions'(Deacon, 2013). The bio-medical model of mental health and illness positioned itself to revolutionise the domain through its propositions on detection, treatment and prevention of mental disorder. The bio-medical model however leaves no room within its framework for the social, psychological, and behavioural dimensions of illness. "The bio-medical model not only requires that disease be dealt with as an entity independent of social behaviour, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes" (Engel, 1977 as quoted in Deacon, 2013: 847).

The 'enthusiastic anticipation'(Kinderman, 2005) surrounding this model was however, in time challenged by the psychological model which voiced its dissent against the reductionism attempted by the proponents of the former, by unequivocally rejecting the psychological, behavioural and social factors that they argued ought to be factored in any mental health intervention. In contrast to the argument forwarded by the bio-medical model, the psychological model predicates an alternative approach that focuses on "…associative networks, based in the neural substrate, but developed through learning and relying on theories of conditioning, perception, appraisal and belief-formation, propositional and implicational encoding, mental models of the world, internalised schemas of relationships etc." (Kinderman, 2005: 209). The argument mooted here is that the core element of individual personality development is pinned on its ability to adjust to the external environment. To the advocates of this school of thought, dysfunction occurs when along the trajectory of development; an individual fails at appropriating the ability to adjust or develops mal-adaptive practices in response and reaction to the external circumstances.

To the canon of literature on mental health, the sociological paradigm has added a significant dimension towards a more comprehensive understanding of mental health. In the view posited by the sociological model, the bio-medical and the psychological stance lead to the pathologisation of the individual. They forward the opinion that mental disorder is not caused by biological and psychological characteristics of the human subjects alone but also by structural features which impacts the role, status, behaviour and resources privileging some members of the society to the detriment of others. Genetic and psychological factors on their own cannot account for mental disorder; cognizance has to be taken of social dynamics in explaining mental health and illness. As Busfield (2000:544) articulates, "Geneticists' reported claims notwithstanding, social processes are crucial to the understanding of mental health and disorder in a range of ways. First, social processes shape the very concepts of mental health and disorder, thereby setting the boundaries of what constitutes mental disorder and the categories that are used to distinguish one disorder from another. Second, social processes play an important part in the aetiology of mental disorders ± any mental disorder is always a product of genetics and environment. Third, social processes play a vital part in influencing mental health practice".

Further, within the ambit of the sociological approach to mental health, some theories have gained precedence in explaining the connection between external environment and its impact on mental health. The stress theory of Selye (1956) postulated how living organisms responded to negative external stimulus in three stages which include flight or fight, resistance and exhaustion. A protracted exposure to negative stimulus builds exhaustion, the stage which culminates into illness. A social environment which has a prolonged negative impact upon individuals, therefore, has the potential to generate illness, including mental illness. The Structural Strain Theory, which draws its inspiration from Robert Merton's Anomie Theory, expounds how a hierarchically stratified society places some groups at an economic advantage while others are put at disadvantageous positions and that economic disadvantage is a strain that brings about psychological disorders.

Several early thinkers (Emile Durkheim, Talcott Parsons, Thomas J Scheff) indicate how an understanding of the concept of mental illness is socially conditioned and anything that resides outside of the pale of socially acceptable behaviour is denigrated as disorder and illness. These references are indicative of the fact that social factors have a substantial role to play in the manner in which mental illness is caused, perceived and addressed and impels one to think beyond biological and psychological factors.

This paper makes an attempt is made to understand mental health and illness particularly that of the women from the social perspective thereby underlining the social epidemiological connect. Gender is a socially constructed identity imposed on the biologically determined male and female sex. The patriarchal structure has proven to be unfavourable to the female sex by relegating them to a position inferior to that of men and imposing upon them socially conceived sanctions, thereby curtailing their rights and freedom. The discriminatory outlook of the society has weighed heavily upon the female psyche and is a causal factor in bringing about mental distress and disorder among the same.

***Gender and Mental Health***

Demographic factors, for instance, age, gender and ethnicity are important in determining the health risks individuals in a society find themselves exposed to. These diverse factors lend their influences in determining the health status (including mental health) of an individual. Table 1 as adopted from McCulloch and Goldies (2010) indicates how the varied factors impacting mental health of individuals may be gauged.

**Table 1: Factors impacting mental health of individuals**

| **Society** | **Community** | **Family** | **Individual** |
|---|---|---|---|
| Equality versus Discrimination | Personal Safety | Family Structure | Lifestyle Factor (diet, exercise, alcohol intake) |
| Unemployment Level | Housing and Access to Open Space | Family Dynamics (e.g. High /low expressed emotions) | Attributional Style (That is, how events are understood?) |
| Social Coherence | Economic Status of the Community | Genetic Makeup | Debt versus Financial Security |
| Education | Isolation | Intergenerational Contact | Physical Health |
| Health Care Provision | Neighbourliness | Parenting | Individual Relationships and Responses to these |

Source: McCulloch and Goldie, 2010.

Of all the factors making themselves palpable in the health status of an individual, the focus here is drawn towards gender and its role in shaping health particularly mental health of individuals. According to the WHO, "Gender is a critical determinant of

 

mental health and mental illness. It determines the differential power and control men and women have over the socio-economic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks"(http://www.who.int/mental_health/prevention/genderwomen/en/). Drawing from this definition, it becomes obvious that the society is stratified along gender lines. The inferior status coupled with truncated rights and liberties that fetter a woman's existence takes its toll on the mental health of the women. Furthermore, socio-cultural norms that endorse women's subjugation, regulation of their behaviour and violence as an instrument of control weighs upon them. Customary norms denying equitable allocation of resources among men and women (favouring the former at the expense of the latter) coupled with constraints that are imposed on their public life leaves them dependent on their male counterparts. This economic dependence translates itself in curtailment of their decision making power, of their participation in political processes, of their independent agency and in negatively impacting upon the overall sense of self-worth of the women.

Women generally seem to be more susceptible to neuroses like distress, anxiety, depression and other somatoform disorders which questions biological genesis of the same and propels attention to the socio-cultural phenomena and its potential in affecting mental disorder. It has been further observed that depression is not just more commonly found among women but may also linger for a longer duration in their lives. It may be averred, thus, that the social stressors in the lives of women may cause consternation in them which in time may debilitate their mental health.

**IV. Social Factors and Mental Health of Women: The Social Etiological Connect**

An important aspect that warrants attention is the high prevalence of post-traumatic stress disorder among women resulting from the preponderance of sexual violence against women in any society. The sociological paradigm has, in present times, emphasised upon the multifarious ways in which socio-cultural factors leave their imprint on the manner in which neuroses and psychosis is shaped. Some of the ways in which socio-cultural dynamics affect mental health may include - *Pathogenic effects*, when culture is a direct causative factor in forming or generating illness; *Patho-selective effects*, when there is a tendency to select culturally influenced reaction patterns that result in psychopathology; *Patho-plastic effect*, when culture contributes to modelling or shaping of symptoms; *Patho-elaborating effects,* when behavioural reactions become exaggerated through cultural reinforcements; *Patho-facilitative effects*, when cultural factors contribute to frequent occurrence and Patho-*reactive effects,* when culture influences perception and reaction (Tseng, 2001).

The socio-cultural aspects which weigh down heavily upon women resulting in a disturbance of their mental health can be explored in the following sections, citing the evidences from the field survey.

***Stress and Mental Health***

Common mental disorder (referred to as non-psychoticpsychiatric morbidity) is characterised by a range of symptoms including anxiety and depression. These conditions have a debilitating effect on the personal and social lives of individuals and are commonly experienced by both men and women. Kuruvilla and Jacob (2007) explain that these, "common mental disorders (CMDs), are reported to be most prevalent among those with the lowest material standard of living, especially among those with a long-term experience of poverty.

Socio-cultural norms vary for men and women of a society. These factors which impose restrictions on women and accords them inferior status in society may often result in mental stress. This is depictive of how inimical social conditions of individuals generate vulnerability for mental disorders among those that find themselves trapped in the same and simultaneously draws attention to the mire of hostile circumstances that women, more than men, have to negotiate in their everyday lives.

Data generated from the field reveals that mental stress, caused by several factors including those generated by socio-cultural norms. Most informants have responded in favour of the argument that mental stress shares a positive relation with mental disorder (Table 2).

**Table 2: Causes of mental illness in women**

| | Frequency | Percent | Valid Percent |
|---|---|---|---|
| Genetic | 140 | 16.9 | 17.4 |
| Mental stress | 236 | 28.4 | 29.4 |
| Over work | 150 | 18.1 | 18.7 |
| Disobeying her husband/elders | 35 | 4.2 | 4.4 |
| Sexual exploitation | 59 | 7.1 | 7.3 |
| Physical illness | 111 | 13.4 | 13.8 |
| Curse | 64 | 7.7 | 8 |
| Others | 8 | 1 | 1 |
| Total | 803 | 96.7 | 100 |
| Non-response | 27 | 3.3 | |
| Total | 830 | 100 | |

Source: Field work, 2014-15

***Religion and Mental Health***

The patriarchal society is endowed with several instruments of control which are employed to regulate social hierarchies with the intent to restrain the weaker sections of the society in their confines of powerlessness and enable the dominant forces to retain their monopoly over social power and resources. One of the early thinkers to have drawn attention towards the concept of religion as a tool of social control is German philosopher Karl Marx (1844).

Marx had categorically pronounced how religion lends itself as a tool in the hands of

 

the socially powerful to keep the disempowered in their present situation. Being favourably disposed towards the empowered class, religion, according to Marx, legitimizes the former's power, authority and control over the hapless groups. As expounded by Marx, religion performs an ideological function related to the idea of reification. Reification wraps in its injunctions ideas that in reality are arbitrary and changeable and posits them as inviolable, immutable and inconvertible. Thus, reification of socio-cultural practices is a more viable form of social control as it generates ideas which reigns each group of society within its ambit of functioning and sustains the traditional structure of power and control.

Religion claims to provide authentic and divinely sanctioned standards of thought, conduct and communal living. It regulates other social institutes of control such as the family and education system. Okon suggests that "religion arrogates to itself the duty of a 'watchdog' and social umpire. As the acknowledged custodian of human ideals and aspirations, religion has always provided a platform for social control" (2012: 141). Thus, religion is an important socio-cultural determinant of the status and power that men and women yield in society. Data generated from the field is in sync with this argument (Table 3).

**Table 3: Impact of religion shaping people's attitude and thought process**

| Reason (as many as) | N-830 | Percentage |
|---|---|---|
| Regulates social life | 666 | 80.24 |
| Ensures moral conduct and ethical behaviour | 571 | 68.79 |
| Preserves social norms | 520 | 62.65 |
| Blinds people from rational thinking | 84 | 10.12 |
| Accords unequal status | 84 | 10.12 |
| Cause of social disruption | 113 | 13.61 |
| Imposes illogical/ unjustified restrictions | 73 | 8.79 |

Source: Field work, 2014-15

Religious sanctions favour men above women thereby categorically delineating the differential status enjoyed by men and women of a given society. The argument here is that such relegation impacts upon a woman's sense of dignity and self-esteem which could be distressful and consequently have an impact upon her overall mental well-being. Table 4 is indicative of how religion restricts the participation of women in various activities. The table suggests that the participation of women is far less in certain rituals (e.g. death rituals, purification rituals) which in traditional society are an exclusive domain of the men.

**Table 4: Degree of participation of women/men in religious rituals/rites**

| Gender | Participatory approach | Marriage rituals | Birth rituals | Death rituals | Purification rituals | Puberty rituals | Other Auspicious rituals |
|---|---|---|---|---|---|---|---|
| Men | Active Participation | 87.1 | 54.6 | 95 | 66.3 | 11.8 | 69.7 |
| | Nominal Participation | 12.5 | 33.2 | 3.5 | 20.7 | 40.2 | 25.7 |
| | Ancillary participation | 0.4 | 3.1 | 0.9 | 7.5 | 27 | 2.9 |
| | Exclusion from participation | 0 | 9.1 | 0.6 | 5.4 | 21 | 1.8 |
| Women | Active Participation | 74.1 | 68.5 | 16.5 | 43.1 | 88.4 | 47.8 |
| | Nominal Participation | 22.2 | 23.1 | 28.7 | 24 | 7 | 45.8 |
| | Ancillary participation | 2.5 | 7.1 | 24.3 | 20.3 | 3.6 | 6 |
| | Exclusion from participation | 1.3 | 1.1 | 30.5 | 12.6 | 1 | 0.4 |

Source: Field work, 2014-15, figures are in percentage

The manner in which religion functions to disempower women, affects the latter's self-esteem. Further, religion educates women to remain submissive to their male counterparts and imposes several other restrictions on them with regard to inheritance of paternal property, choice of partners in marriage, widowhood and other paraphernalia of their social life. All these lead women to internalize the inferior status accorded by religion which does negatively tell upon their self-esteem. Mann (2004) draws attention to the empirical studies conducted in recent past those indicate that self-esteem is an important psychological factor contributing to health and quality of life.

Mental health is significantly affected by self-esteem. The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) throws light on how "negative or unstable self-perceptions are a key component in the diagnostic criteria of major depressive disorders, manic and hypomanic episodes, dysthymic disorders, dissociative disorders, anorexia nervosa, bulimia nervosa, and in personality disorders, such as borderline, narcissistic and avoidant behaviour" (as quoted in Mann *et al*2004:360). Thus, the argument that lack of self-esteem, issuing out of inferior status accorded to women by socio-cultural factors including religion, stand to adversely affect their mental health becomes evident.

***Marriage and Mental Health***

Marriage and child bearing constitute important aspects of a woman's social life. The role of a woman as a wife is characterized by subservience to the husband and his kin and dedication to the children, the elderly and the ailing in the family. In traditional social set-ups, the life of a woman is regulated by the husband and the in-laws, thereby curtailing whatever little independence the woman may have been privileged within her natal house. Unmarried women as also women unable to bear children to sustain family lineage are socially scorned and held in low esteem. Therefore, unmarried women or those who have been divorced/separated from their husbands suffer from great mental duress.

The freedom, status and other privileges that women may have enjoyed in their natal house is compromised in their husband's house post-marriage. Sharma (2013:245) points out how the patriarchal structure functions to ensure complete dependence on

the male sex leading to enormous stress placing the woman's mental health under constant threat. Field data for this paper revealed that from the 52 married respondent women only 22 enjoy the freedom characterised in the preceding discussions.

Batra and Gautam (2013) explained how disruption of marriage can bring about neurotic disorder among couples, particularly the women whose identity, in traditional societies, develops around their fathers and husbands. Marriage has been associated with prevalence of depression among women than among men. Moreover, in traditional Hindu families there exists a rigid code of conduct for women which prevents communication and expression of emotions, especially negative ones, because of which there is higher prevalence of internalizing disorders such as depression in women compared to men"(p. 245).

An important aspect of marriage that bears a direct relevance to mental health of women is that of domestic violence. Violence within marriage is a pretty common phenomenon that mars the life of many married women and makes them vulnerable to mental distress. Most often violence is related to dowry (a characteristic feature of Indian society), which has heaped untold suffering on women and in several cases has led not just to mental derangement, but also death.

***Economic Disadvantage and Mental Health***

In bridging the gaps, the World Health Organization states, "The world's most ruthless killer and the greatest cause of suffering on earth is extreme poverty" (1995: 1). Murali and Oyebode (2004:216) explain on WHO statement that "this statement emphasises the importance of poverty as a variable adversely influencing health. Poverty is a multi-dimensional phenomenon, encompassing inability to satisfy basic needs, lack of control over resources, lack of education and poor health. Poverty can be intrinsically alienating and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioural and psychiatric problems". Economic disadvantage is brought about by low income and inadequate access to resources which characterize the life of women more than that of men.

Table 4 provides an insight into the patient's perspective of poverty and its bearing upon overall mental and physical health of family. Most respondents opined that poverty adversely affected mental health of family members.

**Table 5: Opinion of critical patient towards poverty and its consequences**

| | Frequency | Percentage |
|---|---|---|
| Disturbs mental health | 26 | 25.5 |
| Low social status | 18 | 17.6 |
| Disrupts family well-being | 26 | 25.5 |
| Unfulfilled aspirations/ dreams/ desires etc | 19 | 18.6 |
| Exposure to social threats and other risks | 6 | 5.9 |
| Others | 7 | 6.9 |
| Total | 102 | 100.0 |

Source: Field work, 2014-15

There exists a canon of sociological literature on the connection between economic disadvantage and poor mental health. Murali and Oyebode (2004: 217) explain that "one reason for this phenomenon may be that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequality. Low socio-economic position poses as a deterrent in accessing resources and leaves its imprint on the experience one encounters at personal and professional levels. These socio-economic aspects contribute to negative life experience which in time tells upon one's physical and mental health.

Murali and Oyebode (2004) tell it is the poor who are exposed to dangerous environments, who (if employed) often have stressful, unrewarding and depersonalising work. "Overall people in lower socio-economic classes by virtue of their life circumstances are exposed to more stressors, and with fewer resources to manage them and greater vulnerability to stressors, they are doubly victimised"(2004:217). Table 6 upholds how majority of women face stress in managing household expenses within the limited economic resources.

**Table 6: Income of the households and women facing difficulties to run**

| Monthly income of the households | Total sampled households | Difficulties | | | |
|---|---|---|---|---|---|
| | | To arrange two square meals | To ensure education for the children | To ensure health related expenses | To ensure all three aspects- meals, education and health |
| Up to 1000 | 29 | 19 | 1 | 3 | 6 |
| Between 1001 to 5000 | 345 | 32 | 35 | 64 | 214 |
| Between 5001 to 9000 | 252 | 17 | 33 | 49 | 153 |
| Between 9001 to 13000 | 83 | 2 | 5 | 25 | 51 |
| Between 13001 to 25000 | 38 | 0 | 2 | 6 | 30 |
| Above 25000 | 10 | 0 | 0 | 3 | 7 |
| Total | 757 | 70 (9.2) | 76 (10.0) | 150 (19.8) | 461 (60.9) |

Source: Field work 2014

## V. Conclusion: The Bio-psychosocial Model of Mental Health

This review paper drawing some field insights explored the social epidemiological connection in the context of mental health of women. Dominated by the biological model, mental health for long stood to be addressed interns of bio-genetics alone till the psychological model and thereafter the sociological model presented fresh ideas

 

with respect to a holistic understanding of mental health. In this paper, the centre stage has been occupied by the sociological model, drawing from which, some aspects of socio-cultural life that have a bearing upon the mental health of women have been explored. The moot point here is to focus on the debilitating effect that negative social factors have on mental health particularly that of women's mental health owing to the historical socio-cultural disadvantages they suffer from. It warrants that the domain of mental health should take within the ambit of consideration social causative factors in addition to those put forward by medical sciences in adequately addressing the issue.

The paper though largely attributes to the social causative factors to address mental health, however, does not stand to deny credence to the other models, viz. the psychological model and the biological model. Rather, it is suggested that the three models should work in tandem to address the domain of mental health. In conclusion we may recall the words of Ghaemi, "no single illness, patient or condition can be reduced to any one aspect (biological, psychological or social). They are all, more or less equally, relevant, in all cases, at all times" (2009: 3).

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