MENTAL HEALTH CARE: A REVIEW OF GENDER DIFFERENCES

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ABSTRACT

This paper focuses on gender differences on mental health care with particular reference to the Indian scenario. A critical analysis of the literature reveals that firstly, a large amount of mental distress among women remains unrecognised and untreated. Secondly, a number of mental disorders which disproportionately affect women are related to their work and position in society, rather than to biological factors alone. Thirdly, due to social and gender inequity, women receive less than their share of benefits of mental health services. These findings have disturbing implications in the light of the National Mental Health Programme's exclusive reliance on a biomedical approach. Findings from a recent study, conducted in two psychiatric facilities in Andhra Pradesh, are presented which provide further confirmation of this pattern of gender differences in mental health care.

KEY WORDS : Gender and mental health; Mental health facilities

INTRODUCTION

It is by now widely acknowledged that health is a multi-dimensional phenomenon. The levels and distribution of income, social and cultural practices and perceptions regarding health and illness, and the choice of technology, do influence the physical and mental health status of a society (1). The health status of people in developing countries in particular, needs to be understood according to social conditions that include access to basic amenities like food, drinking water, housing, education, employment, transport, communication and so on. In addition, people's perceptions of sickness and health, which in turn are based on several social, economic and cultural factors, and the role of the state in shaping health services are all instrumental in determining the health status of people (2).

Another feature of developing countries that has been well documented, is the critical gap between availability and accessibility of health care services. This gap has been particularly instrumental in excluding a large proportion of the rural population and marginal communities such as the tribal groups in India (3).

The patterns of reporting of morbidity also reveal important pointers not only to the health status of various groups, but also to inequalities in status and autonomy among various groups of individuals (4). Achieving better health care therefore cannot be based on an exclusively biomedical approach to human suffering, but has to involve an awareness of social factors impinging on health status and in the larger context, a struggle for equitable social relations.

One of the critical issues in health care that has received substantial attention from researchers in recent years is that of gender differences in health. It is by now well established that gender differences in health and mortality, particularly in the South Asian region do exist (5). What is relatively neglected is the pattern of gender differences in access to mental health care services in India. The purpose of this paper is to highlight this issue, with specific reference to findings of studies conducted in northern Andhra Pradesh, a state in southern India.

MENTAL ILLNESS AND MENTAL HEALTH SERVICES IN INDIA

Mental health problems currently are said to constitute about eight per cent of the global burden of disease and more than 15 per cent of adults in developing societies are estimated to suffer from mental illness (6). According to the new concept of measuring disability called Disability Adjusted Life Years (DALY), mental disorders constitute a significant part of total disability adjusted life years (8.1%), more than the disability caused by several well recognized disorders such as cancer (5.8%) and heart diseases (4.4%) (7). Mental disorders may not produce high mortality rates (except for a proportion of suicides) but do give rise to high morbidity which implies debility or disability. The seriousness of the

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problem in India is indicated by the fact that the estimated overall prevalence rates of mental illness vary from 9.5/1000 to 102.5/1000. It is further estimated that nearly thirty million suffer from mental illnesses every year and that 175,000 new cases are added every year (8).

It was commonly believed that the prevalence of mental illness in India was much less than in the western countries, citing the 'oriental philosophy of life', the limited urbanisation and industrialization, and the strong family ties as factors responsible for the 'low prevalence' of mental illness. Representative surveys of mental morbidity were also not taken up till the 1960s. Since then however, the accumulated evidence based either on hospital data or community surveys, points out that the prevalence rate of mental illness in India is not significantly less than that in the west. However, much of the work in the area of mental health continues to be directed at treatment of illness, rather than towards preventive or promotion efforts.

The mental health services in India consist of specialized mental hospitals, psychiatric units in general and teaching hospitals, private mental health clinics and nursing homes, voluntary sector services, traditional services ranging from homeopathy and ayurveda to magico-spiritualism, and the National Mental Health Programme introduced in 1982. The conditions in the state mental hospitals have been pointed out to be dismal in terms of treatment, care, accommodation and nutrition (9). The average expenditure per patient per day is between Rs. 20 and Rs. 30, which is grossly inadequate. Despite an increase in the number of mental hospitals from 30 in 1951 to 45 in 1991, there is an acute shortage of beds. Moreover, most of the beds are in urban areas, thus excluding the vast majority of the rural population from easy access to mental health facilities (10). The dominant modes of treatment are chemotherapy and electrotherapy; the availability of other modes such as child guidance clinics, occupational therapy units, detoxification centres and follow-up clinics, is secondary and varies considerably across institutions. Another serious lacuna of the mental health programme in India has been the medically trained psychiatrists with adequate para-professionals such as psychotherapists and counsellors, and psychiatric social workers. There is a shortage of psychiatrists as well, with only two psychiatrists per 10 lakh population as against 150 per 10 lakh population in USA, for instance (11).

The services of the private clinics and nursing homes and those in the voluntary sector are limited in scope and confined to small sections of the urban population. The traditional services, for their part, are not able to provide a clear alternative facility to people. Furthermore, despite the large number of native healers, exorcists, shamans and charlatans of mental healing, it is not clear at what level people use these services (12).

The picture that emerges from these findings is the gross inadequacy of facilities for mental health care. It is also important to know whether health care is equitable across gender, whether as many women receive treatment for their mental illnesses as they are suffering. Particularly, in view of the fact that gender bias in several aspects of society including health care is an accepted reality, it is a legitimate concern whether such bias exists in mental health care as well. Before we go into the evidence of such a bias, it would be appropriate to provide a brief overview of women's mental health from the gender perspective.

WOMEN AND MENTAL ILLNESS

Mental disorders are not randomly distributed throughout a population, but rather subgroups differ in the frequency of various disorders. Knowledge of this uneven distribution can be used to investigate causative factors and to lay the groundwork for programs of prevention and control. More women than men, the world over, are said to suffer from mental disorders. Historical evidence dating from the 19th century, points to asylum statistics in Europe, confirming that female inmates outnumbered their male counterparts (13). Both community surveys and hospital-based studies indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with their marital status, work and roles in society (14). Women's mental health cannot be considered in isolation from social, political and economic issues. Examination of women's position in society reveals that there are sufficient causes in current social arrangements to account for the surfeit of depression, anxiety and distress experienced by women. Consideration of women's mental health therefore requires recognition of the impact of social factors on mental health, a position that challenges traditional intrapsychic, biomedical approaches to mental illness.

Mainstream psychological approaches to mental disorders, for their part, have largely been gender-blind and gender-insensitive. Viewing mental illness

from the biomedical model, these approaches usually consider somatic and psychological factors in their diagnostic efforts, overlooking the impact of social-cultural factors. On the other hand, it has been feminist psychological research that has pointed out that consideration of women's mental health requires recognition of the impact of social factors on mental health. It is feminist research rather than mainstream psychological research, that has demonstrated the ways in which social inequities and social assumptions about womanhood influence different aspects of women's lives, and thereby their physical and emotional health.

Recent research has demonstrated the impact of social circumstances upon women's private experiences and actions (15). Whether it is denial of economic resources, education, legal and health services deprivation, lack of physical and mental nurturance, exhaustion from overwork, or sexual and other forms of physical and mental abuse across the life span, research corroborates that it is women who are at the greatest risk. These issues not only fall within the fabric of human rights, but also are those which understandably affect mental health (16). In addition, the routine of women's lives render them at risk to experience more stress than men. This reflects the greater number of social roles women fulfill as wife, mother, daughter, care-giver and an employee. Furthermore, women's reproductive role as bearer and nurturer of children, produces unique potential for stress related effects. Thus, the well-documented higher morbidity in women's health across the life span has clear biosocial underlying causes.

There is accumulating evidence that links mental disorders with poverty, powerlessness and alienation, conditions most frequently experienced by women. In fact, three of the five priority areas outlined in the National Institute of Mental Health document USA namely-violence, multiple roles and poverty, focus specifically on the ways in which women's actual experience and their subordinate position in society contribute to problems in their mental health (16).

There are two main routes through which women's position in society might contribute to poor mental health outcomes, one indirect and the other more direct and extreme. The first is concerned with role-related stressors including multiple role strain, role overload and role conflict. The second includes actual sexual victimization whether through brutal stressors like rape, battering, or other forms of violence against women. While experiences of gender oppression – ranging from employment discrimination and sexual violence to trivialization of women's work – occur with regularity, the accumulation of such experiences help account for mental health risks that disproportionately affect women, such as depression, anxiety and phobic disorders (17).

Frequencies and patterns of mental disorder have been found to be vastly different for men and women. In the western context, the widely acclaimed NIMH Epidemiological Catchment Area Program, which sampled the non-institutionalised population, found that for the 15 diagnostic categories studied, there were substantial gender differences in prevalence rates of lifetime diagnoses: (a) women predominated in diagnosis of major depressive episodes, whereas men predominated in antisocial personality and alcohol abuse/dependence; (b) women were more likely than men to have received a diagnosis of dysthmia, obsessive-compulsive disorder, schizophrenia, somatization and panic disorders ; and (c) no gender differences were apparent in manic episode or cognitive impairment (18).

Patterns of gender differences for six-month prevalence rates also indicated that major depression, phobias, dysthmia and obsessive-compulsive disorder were the most common diagnoses for women. Men on the other hand, predominated in alcohol abuse/dependence (19). This pattern of gender differences in diagnoses has also been found to vary by marital status and class. While single and widowed/separated men have been found to have higher overall admission rates than women in the same marital status categories, married women have higher admission rates than married men. This has been the pattern in the western context, despite variations across samples of different ethnic categories (20). In India however, in addition to the higher frequency of illness in married women, a higher frequency has been found in single women as well, when compared to single men (21).The difference between the findings of the western and Indian studies can perhaps be attributed to cultural differences in the centrality of the institution of marriage. While the potential stressors associated with marriage are reported to be applicable to women, the social stigma and related tensions attached to single status have more adverse effects on women once again.

The findings underscore the importance of understanding complex relationships among gender, ethnicity, sex roles and mental health if effective mental health policies and programmes are to be developed. Furthermore, the psychosocial nature of

these variables points to the need to go beyond narrow biomedical approaches in building the research knowledge base.

In the Indian context, although epidemiological investigations of mental health have been conducted since the 1960s, albeit in a scattered manner, studies on mental health needs of women are meagre, if not altogether lacking. There have scarcely been any focused studies on gender differences in the prevalence of disorders or access and utilization of mental health services, and on the specific vulnerabilities of women in various age, occupational, and socio-economic groups.

It was only recently that a gender-sensitive analysis, possibly the first of its kind in the country, of the data gathered in these epidemiological studies was made, which questioned the gender-biased assumptions of earlier research and highlighted the psychosocial stressors associated with women's position and roles in society (22). Drawing on the data gathered by epidemiological studies conducted in our country since the 1960s, Davar (1999) in her critique of these studies, pointed out that despite their methodological shortcomings and politically misleading inferences, the data converged qualitatively on some significant dimensions of being a woman with mental distress in India. While no marked gender difference has been seen in the case of severe mental disorders that have a biological basis, women were found to be at least twice as frequently ill as men in the case of common mental disorders (or the erstwhile psychoneurotic disorders) which have a psychosocial etiology. In other words, where mental illness has a biological etiology, as in the case of severe mental disorders, frequency of illness is the same across gender. On the other hand, where mental illness has a psychosocial basis, more women have been found to be mentally ill than men. Therefore, a bio-medical approach to women's mental health is inadequate, since a larger part of mental disorder epidemiology in women is constituted by the common mental disorders whose causes are located in psychosocial factors. This underscores the necessity of adopting a different and exclusive approach to women's mental health concerns.

The National Mental Health Programme (NMHP, introduced in 1982) however, does not have a women's mental health agenda, despite its stated objective of "ensuring availability of minimum mental health care for all..., particularly to the most vulnerable and under-privileged sections of the population" (23) . Furthermore, adverse implications for women follow from the focus of the NMHP on the mental illness categories that it has chosen for intervention, namely-epilepsy, mental retardation, and the psychoses, which are severe disorders.

UTILIZATION OF MENTAL HEALTH SERVICES

Mental health services at the institutional level are provided at different stages in India (24). There are five levels through which an individual eventually becomes an in-patient, at a mental hospital. Level 1 refers to unidentified morbidity in the community, about which community surveys provide us with information. Level 2 refers to people presenting themselves at primary health centres and general practitioners with distress symptoms, but who are not yet identified as 'cases'. Level 3 refers to identified 'cases' by these same services. At level 4 are individuals reaching hospitals, both the general hospitals and mental hospitals. Finally at level 5 are individuals admitted as in-patients in the psychiatric wards of general hospitals or in the mental hospitals.

The number of people receiving care at different service outlets is determined to a large extent by their socio-demography including gender, caste and class variables. Who has access to what kind of mental health services, depends to a considerable extent on the user's social and economic class status and gender. The utilization rates of mental health services need not necessarily be directly related to the prevalence of disorders but may be coloured by the social location of the user.

In the west, there is parity of access to health care by both the sexes and therefore hospital statistics provide a sufficiently clear picture of prevalence of disorders in men and women. Comparisons of community survey rates of mental illness and hospital rates do not grossly differ in the western context. In India however, the health care services are marked by gender-based inequity of access to hospital care. In such a case, drawing conclusions about the comparative prevalence of mental illness in men and women based upon utilisation data from hospital samples is therefore both questionable and misleading. The hospital-based studies conducted in India have recorded a predominance of male patients from which researchers have concluded that there is a greater frequency of mental illness among men. The explanation offered by some of the researchers is that it is men who carry the onerous burden of responsibility and stress while women have a relatively stress free time. In her critique of epidemiological studies in the country, Davar points out that such explanations are too facile and

"methodologically questionable and politically misleading" (25). She argues that firstly, these studies have been based on hospital samples using data on utilisation of hospital facilities and services as if they were prevalence data. While doing so, these researchers, according to Davar, have glossed over the fact that there is gross gender-based inequity of access to health care in this country. Secondly, to say that it is only the male role that is stressful is to overlook the compelling and crucial issues that the women's movement over the past several years has been drawing our attention to the potentially stressful factors affecting women's psychological health such as the unequal work distribution, unequal decision making power, unpaid labour, and rigid role functions and stereotyping. To ignore these issues therefore and to conclude that the supposedly greater prevalence of mental illness among men is due to greater stress, reveals a gender-blind approach.

Community surveys, on the other hand, from the 1970s to the 90s have recorded a greater female morbidity. Patterns of mental disorder too vary markedly for men and women, whether data from community surveys or from hospital studies are used. Most of the studies show that women report significantly more frequent symptoms of common mental disorders. The overall gender based difference in prevalence of severe disorders, on the other hand, is negligible compared to the overall difference in the prevalence of common disorders (26).

From a gender perspective this divergence between the data obtained from hospital samples and community surveys, and between patterns of mental disorder in men and women, has important implications for the mental health programme in the country.

Two inferences can be drawn from these findings:

a) The pattern of predominance of male patients in hospital statistics indicates restricted access of women to health care services. The fact that in community surveys across the country, more 'unidentified cases' of women have been reported, indicates that women's mental distress is either untreated or they may be seeking help from alternate settings at levels 2 and 3 (PHCs and GPs) or from native healers. This is speculative, in the absence of clear evidence.

b) The approach of hospital services and treatment programmes, characterised chiefly by electrotherapy and chemotherapy and geared for severe mental disorders, is inadequate for dealing with the illnesses of women, which differ in nature and aetiology and the kind of treatment required.

Since there is a paucity of traditional psychiatric services such as counselling centres in the country, what this means, is that women, for whom a biomedical approach is inadequate to deal with the symptoms of common mental disorders, do not have recourse to appropriate psychological help. These inferences have been borne out in our study on socio-demography of mental disorders that we conducted in Andhra Pradesh.

THE ANDHRA STUDY

While the larger project was concerned with obtaining a global picture of the frequency distribution of various mental disorders and delineating the risk groups in terms of socio-demographic correlates of each disorder, only the gender differences in patterns of mental disorders and their implications for access to health care facilities will be discussed in the present paper. Data collected from hospital case records of 11,726 patients registered over a five-year period, i.e. 1991-1995, in two major psychiatric facilities in Visakhapatnam, in the north coastal region of Andhra Pradesh, formed the basis of this study. The two institutions from which the data were taken were the Government Hospital for Mental Care (GHMC) and a private hospital named Shanti Niketan (SN). The catchment area of these facilities is not only the city of Visakhapatnam, but also the entire north coastal region and the adjoining districts of the neighbouring states of Orissa and Madhya Pradesh, which are characterized chiefly as economically backward. The GHMC, established in 1863, is the oldest and one of the two state hospitals in Andhra Pradesh. It has a bed strength of 300 (225 for men and 75 for women). SN, established in 1984 has presently 12 beds with 10-15 patients attending the out-patient clinic daily. The psychiatric diagnosis were made as per the tenth revision of International Classification of Disorders (ICD).

The two hospital samples showed a predominance of male patients with 62% of the total sample being men, while only 38% were women patients. The gender gap was slightly narrowed in the case of the private hospital sample, where the proportion of male and female patients was 56% and 44% respectively. The implications drawn from research findings mentioned in the section above seem to hold good for this study too. Hospital statistics confirm an overall over representation of male patients, although this might not correlate with

prevalence rates of distress in the community. The deduction then is that women are under-served by hospital services.

The patient profile of the government and private hospitals showed further differences, which are again in accordance with earlier research findings in psychiatric epidemiology. While patients from rural areas and lower socio-economic groups formed the bulk of persons seeking help in the government hospital, the private hospital had a relatively higher urban, better-educated and economically advantaged clientele. It is women from the urban, educated and comparatively higher socio-economic groups that had access to the facilities of the private hospital. Therefore, despite the higher frequency of male patients in both the samples, the related findings mentioned above point to the relatively better access of women from the upper socio-economic strata to the private facilities and the poorer access of women from disadvantaged sections to state hospitals. In fact it has been recognised, in recent years, that mental health services are not evenly distributed in the country. Access and quality of such care services has been found to be the best for economically advantaged men in the cities, with women from city slums and rural areas receiving the least satisfactory services in the country (27) .

Patterns of mental disorders also were found to be different for women and men. Despite an overall predominance of men in both severe and common disorders, the following disorders were found to affect women more.

1. Prolonged depressive reaction
2. Mixed anxiety and depression
3. Somatoform disorders
4. Dissociative disorders

All these disorders belong to the category of common mental disorders and this gender-specific pattern of mental disorders is in accordance with earlier findings of higher frequency of common mental disorders among women. The causes for these disorders are located in the psychosocial context of women's lives rather than in biological/ organic factors alone. It is not surprising that women's mental ill-being is predominantly manifested through depression, preoccupation with bodily complaints and trance-like experiences characteristic of these disorders. These symptoms constitute culturally shaped 'idioms of distress' that are employed to express concerns about a broad range of personal and social problems and their origins are closely associated with women's work, position and roles in society. The vulnerability of women to these kind of disorders, wherein cognitive impairment and social breakdown might not be marked but nevertheless have a high degree of personal distress, indicates the necessity of making available appropriate mental health care services that women need in our society.

CONCLUSION

Prevalence of mental distress is an important indicator of the well-being of a community and is significantly differentiated by gender. Literature provides us with evidence of gender differences in the nature of disorders as well as in the access to health care facilities. It has been argued that instead of an exclusive biomedical approach, psychosocial approaches to mental illness have a critical role to play, if we are to achieve better understanding of the aetiology, treatment and prevention of mental disorders, particularly in women.

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