GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

INAUGURALDISSERTATION

zur

Erlangung der Würde einer Doktorin der Philosophie

vorgelegt der

Philosophisch-Naturwissenschaftlichen Fakultät

der Universität Basel

von

Shubhangi Raghunath Parkar

aus Mumbai, India

Basel, Januar 2003

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Genehmigt von der Philosophisch-Naturwissenschaftlichen Fakultät der Universität Basel auf Antrag von

Herrn Prof Dr. Marcel Tanner, Herrn Prof. Dr. Mitchell Weiss und Frau Prof. Dr. Anita Riecher-Rössler.

Basel, Januar 2003

Prof. Dr. Marcel Tanner

Dekan

Dedication

I dedicate this work to my late sister, Advocate (Miss) Sheela Parkar, for teaching me to live through sufferings. She gave me tremendous insight into suffering, suffering and suffering. She survived for a few years after her bone marrow transplant. The death was knocking at her all the time. She showed unbelievable strength in facing her doom, day in and day out. She was a picture of courage personified.

Dr. Shubhangi R. Parkar

GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

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First I am ever grateful to my parents Mr Raghunath S. Parkar (Daddy) and Mrs Kalindi R.Parkar (Aai) whose only mission in life is to see their daughters (they have no sons) progressing in the era where gender discrimination is an universal issue. I thank both of them for instilling so much courage and confidence in me. I am blessed by wonderful sisters, Vandana, Sarita, Swatu (I miss you tremendously Sheela) who share everything I do, and then my work becomes our work, and my hardships become our hardships, and my happiness becomes our happiness. In short, I do not consider myself as an individual but as a part of our family of sisters, sheltered and loved by our parents. I am happy to share my joy with my intelligent and lovely nieces, Ishu and Shreeyu, who are waiting to get hold of my PhD. (They think it is Swiss chocolate.)

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only a senior member of my team but also a friend, philosopher and guide. His support through my personal turmoil and PhD work is unforgettable. I thank Mrs. Pradhan for her attentively caring for administrative matters during my stay in Basel. My special appreciation goes to my dearly loved students, and among them in relation to this work, I would like to mention Roopali, Sharon, Shaunak, Javed, Sumbul, Varsha and Ranjana. I also thank Johnson Fernandez for his special efforts in building our rapport with the Malavani community. I recognise and appreciate all my friends, who have shown their willingness to stand by me anytime and make my life comfortable at any cost.

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As I am engaged in cultural epidemiological studies, I am delighted to perform my most important duty—to salute my Indian culture, which taught me to be dignified, committed, and to respect humanity and other cultures, come what may. I hope I have done my duty (*karma*) to the best of my ability. *Jai Hind*.

Summary

By 2015 it is expected there will be 23 megacities, and all but four will be in developing countries. Mumbai, which now has a population in its metropolitan area of 16.4 million (Census of India, 2001), will then be the world's second largest city after Tokyo. Three other cities in India (Kolkata, Delhi, and Hyderabad) and two more in South Asia (Dhaka and Karachi) will also join the ranks of these megacities. In Asia and Africa such demographic shifts into cities have been especially challenging, and the environmental and social impact of unbridled urban expansion on infrastructures affecting health status has become a priority for public health. It is recognised that the urban poor are especially vulnerable to these adverse effects of urbanisation, but the topics of culture and gender have attracted far too little interest, especially in mental health research and policymaking.

Various accounts of international health agencies concerning the needs and approaches to the mental health of populations highlight the broader social, cultural, and economic contexts, for which clinical experience alone is an inadequate guide. Changing social values and the influence of globalisation require timely consideration of the role of gender. Mainstream psychiatric priorities advocate a model of mental disorders that has become less attentive to the impact of social conditions than many aspects of clinical practice and effective community mental health programmes require. Such considerations indicate the need to re-establish the balance between these interests and current research priorities in psychiatry, which emphasize the biological basis of mental disorders and criteria-based definitions based on clinical, rather than community, experience and research. Informed policy, which is attentive to the local contexts of needed mental health actions, requires more relevant research as a guide, responsive to recommendations

of major policy reviews reported in the *World Mental Health Report* (Desjarlais et al., 1995) and the WHO's (2001) world health report on mental health.

The field of cultural psychiatry has long been grappling with a tension between needs to pursue psychiatric epidemiological study of mental disorders in Asia and Africa, which have long motivated developments in transcultural psychiatry, and questions about the limitations of dominant paradigms of psychiatry, which motivated subsequent rethinking of the new cross-cultural psychiatry. Questions about interactions between gender and culture, however, have been for the most part subordinate among priorities in the field. Research is needed on mental health problems to examine explain interrelationships among gender and culture as a complement and integral feature of psychiatric epidemiology—addressing questions of why, how, and what to do—and to make languages and priorities of patients, communities and professionals more mutually comprehensible.

A common theme links the various studies that comprise this thesis. It is a focus on local representations of various mental health problems in both clinic and community settings in urban Mumbai, with particular attention to questions of gender. Formulating these studies in both clinical and community settings provided valuable opportunities to consider a broader agenda of mental health interventions rooted in, and aiming to restore, a more contextual formulation of a biopsychosocial model. The research reported in this thesis has been motivated by the clinical professional and personal experience of the author in Mumbai, focussing the work on particular themes of cultural context, gender and common mental health problems. These studies highlight the concept of common mental health problems because the nature of the problems that arise in the course of evaluating deliberate self harm (DSH) and the mental health-related issues that arise in dealing with both clinic patients and

community residents are not restricted to the formal professional concepts of psychiatric disorder. Our studies of DSH have examined underlying sociocultural and psychiatric problems and identified triggers of suicidal actions. Expected gender-specific contexts were identified, such as alcohol and other substance dependence disorders among men and victimisation among women. Furthermore, a number of individuals also described their problems in terms that contradicted the gender stereotypes. For some conditions, such as substance use disorders, mental health problems had substantial impact on people living with affected person, indicating a hidden burden.

The research has been especially attentive to the influence of social and cultural factors in Mumbai that affect mental health—factors such as economy, unemployment, poverty, and the gendered dynamics of family interactions. The nature and formulation of categories of distress, perceived causes, and health seeking were clarified in community dialogues through ethnographic community study, clinical interactions and clinical cultural epidemiological study using locally adapted EMIC interviews. Our cultural epidemiology provides an account of the distribution of the categories of experience, meaning and behaviour, which constitute locally valid representations of mental health problems. These studies proceeded at two different sites in Mumbai. The ethnographic community study was undertaken in the Malavani slum, 35 kms north of central Mumbai in a western suburb. The study of DSH was based at the second site in the KEM Hospital, which is the largest hospital in Mumbai. It proceeded in cooperation with colleagues in the emergency medical department to ensure systematic referrals of all patients who met criteria for study.

The research reported in this thesis demonstrated how cultural epidemiology supported by ethnography may complement psychiatric epidemiology to guide clinical practice and mental health policy. Collectively, the studies in this volume suggest the value of ethnographic data for identifying categories of experience, meaning, and behavior, which clarify locally important features of common mental health problems. The research on DSH examined the relationship between clinical diagnoses based on DSM-IV criteria and patient-perceived determinants of suicidal behavior ascertained in EMIC interviews. This perspectivism has guided complementary psychiatric and cultural epidemiological assessments of suicidal behavior. Locally relevant features, attentive to the impact on suicidal behavior of psychopathology, underlying problems patients relate to their DSH, and stressors that constitute triggers of suicidal behavior should all inform suicide prevention, community mental health interventions, and clinical practice.

The research reported in this thesis contributes to a novel approach that provides gender-sensitive information of practical significance for designing services and programmes in urban settings of low-income countries. Individually and collectively, these studies are addressing practical and highly relevant issues that mental health policy must address in India's cities, both in communities and clinics of slums and in middle-class neighbourhoods. In addition to their contribution to mental health at these sites, it is hoped that the example of these studies will also clarify an approach to cultural epidemiological research that will be useful in other settings.

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ZUSAMMENFASSUNG

Man schätzt, dass bis im Jahre 2015 dreiundzwanzig Megastädte existieren werden. Nur vier dieser 23 Städte werden nicht in Entwicklungsländern sein. Mumbai, dessen Bevölkerung im Grossstadtgebiet sich zur Zeit auf 16,4 Mio beläuft (Census of India, 2001), wird dann die weltweit zweitgrösste Stadt nach Tokyo sein. Drei weitere indische Städte (Kolkata, Delhi und Hyderabad) und zwei weitere in Südasien (Dhaka und Karachi) werden dann auch zu den Megastädten zählen. In Asien und Afrika stellen solche demografischen Verlagerungen in die Städte eine besondere Herausforderung dar. Die sozialen und umweltbezogenen Auswirkungen solcher ungezügelter Urbanisierung auf Infrastrukturen, die die Gesundheit betreffen, sind mittlerweile eine Priorität für das öffentliche Gesundheitswesen geworden. Es wurde erkannt, dass speziell die städtischen Armen durch diese negativen Auswirkungen der Urbanisierung gefährdet sind, aber die Themen Kultur und Geschlechterbeziehungen haben wenig Beachtung erhalten, besonders in der Forschung von psychischer Gesundheit (*mental health*) und der Erarbeitung von Gesundheitsrichtlinien (*policymaking*).

Verschiedene Berichte von internationalen Gesundheitsagenturen betreffend den Bedürfnissen und Ansätzen in psychischer Gesundheit der Bevölkerung betonen die umfassenden sozialen, kulturellen und ökonomischen Kontexte, für welche rein klinische Erfahrungen ein unzureichender Leitfaden sind. Das Verändern von sozialen Werten und der Einfluss der Globalisierung erfordern eine rechtzeitige Beachtung der Rolle der Geschlechtserbeziehungen. Etablierte psychiatrische Prioritäten befürworten ein Modell von psychischen Störungen, welches den Auswirkungen von sozialen Umständen weniger Aufmerksamkeit schenkt als nötig

wäre für viele Aspekte der klinischen Praxis und für wirkungsvolle gemeinde-basierte Programme für psychische Gesundheit.

Solche Betrachtungen weisen auf die Notwendigkeit hin, die Balance herzustellen zwischen diesen Interessen und den gegenwärtigen Forschungsprioritäten in der Psychiatrie, welche die biologische Grundlage von psychischen Beschwerden betonen und kriteriumsbezogene Definitionen, die auf klinischen Erfahrungen und Forschung statt auf gemeinschaftsbezogenen Erfahrungen basieren. Das Erstellen von sachkundigen Richtlinien, welche die lokalen Kontexte von Aktivitäten zur Förderung der psychischen Gesundheit beachten, benötigt mehr relevante Forschung als Leitfaden. Diese Richtlinien müssen die Empfehlungen von wichtigen Dokumenten über Strategien Ernst nehmen. Dazu gehören der *World Mental Report* (Desjarlais et al., 1995) und der *World Health Report* der Weltgesundheitsorganisation über psychische Gesundheit (WHO, 2001).

Das Fachgebiet der kulturellen Psychiatrie hat sich lange mit einer Spannung abgemüht. Diese Spannung besteht zwischen der Notwendigkeit, psychiatrische epidemiologische Studien von psychischen Beschwerden in Asien und Afrika zu betreiben (was lange die Entwicklung der transkulturelle Psychiatrie angetrieben hat) und Fragen über die Grenzen der dominierenden Paradigmen in der Psychiatrie. Dies führte zum Überdenken der neuen transkulturellen Psychiatrie. Fragen über Wechselbeziehungen zwischen Geschlechterbeziehungen und Kultur haben jedoch in den meisten Fällen keine Priorität auf diesem Gebiet erhalten. Forschung über psychische Gesundheitsprobleme ist nötig, um die gängigen Erklärungen betreffend Wechselwirkungen zwischen Geschlechterbeziehungen und Kultur zu untersuchen, und zwar als ein ergänzender und wesentlicher Teil der psychiatrischen Epidemiologie. Fragen wie „Warum?“, „Wie?“, und „Was ist zu tun?“ müssen in

Angriff genommen werden. Forschung ist auch nötig, um eine besseres gegenseitiges Verständnis zu schaffen, was die Ausdrucksweise und Prioritäten der Patienten, der Leute allgemein und der Fachleute betrifft.

Ein gemeinsames Thema verbindet die verschiedenen Studien, die diese Doktorarbeit enthält: einen Fokus auf die lokalen Repräsentationen von verschiedenen psychischen Beschwerden sowohl in Kliniken als auch in Wohngebieten im städtischen Mumbai, mit besonderer Berücksichtigung der Fragen der Geschlechterbeziehungen.

Die Erarbeitung dieser Studien sowohl in Kliniken als auch Wohngebieten lieferte wertvolle Möglichkeiten, ein breitgefächertes Programm von Interventionen für die Verbesserung der psychischen Gesundheit zu erwägen, verankert in einer mehr kontextualisierten Formulierung eines Biopsychosozialmodells, die auch zum Ziel hat, ein solches kontextualisiertes Biopsychosozialmodell wieder herzustellen.

Die Motivation für die Forschung, über welche in dieser Doktorarbeit berichtet wird, basierte auf den klinischen beruflichen und persönlichen Erfahrungen der Autorin in Mumbai, welche ihre Arbeit auf bestimmte Themen von kulturellem Umfeld, Geschlechterbeziehungen und häufigen psychischen Gesundheitsproblemen ausrichtete. Diese Studien heben das Konzept der üblichen psychischen Gesundheitsprobleme hervor. Der Grund dazu ist folgender: die Art der Probleme, die auftauchen, wenn man sowohl „*deliberate self harm*" (DSH) („die absichtliche Verletzung der eigenen Person") evaluiert als auch psychische Gesundheitsthemen, die auftreten, wenn man sich mit Patienten und Leuten in den Wohngebieten befasst, beschränkt sich nicht auf rein professionelle Konzepte von psychischen Störungen. Unsere Studien über DSH haben zu Grunde liegende soziokulturelle und psychiatrische Probleme untersucht und Auslöser von suizidalen Tätigkeiten

identifiziert. Erwartete geschlechts-spezifische Kontexte wurden gefunden (z.B. Alkohol- und Drogenabhängigkeit unter Männern und Viktimisierung der Frauen). Aber einige Personen beschrieben ihre Probleme auch auf eine Art und Weise, die den Stereotypen der Geschlechterbeziehungen widersprachen. Einige psychische Störungen, z.B. Drogenabhängigkeit, hatten eine starke Auswirkung auf Personen, die mit diesen Leuten zusammenlebten. Dies weist auf eine verborgene Belastung (*hidden burden*) hin.

In dieser Forschungsarbeit wurde speziell auf den Einfluss von sozialen und kulturellen Faktoren in Mumbai geachtet, welche die psychische Gesundheit beeinflussen - Faktoren wie die wirtschaftliche Situation, Arbeitslosigkeit, Armut und die geschlechts-spezifischen Dynamiken in Familieninteraktionen. Die Natur und der Ausdruck von verschiedenen Arten von Leiden (*categories of distress*), empfundenen Kausalfaktoren (*perceived causes*), und der Suche nach gesundheitsbezogenen Hilfeleistungen (*health seeking*) wurden abgeklärt durch Gespräche mit gewöhnlichen Leuten durch ethnografische Studien, durch klinische Interaktionen und durch kulturelle epidemiologische Studien („*cultural epidemiological studies*"), die EMIC Interviews, welche an die lokale Situation angepasst waren, einsetzten. Unsere kulturelle Epidemiologie („*cultural epidemiology*") erfasst, wie die verschiedenen Krankheitserfahrungen, Bedeutung und Verhaltensmuster in einer Studienbevölkerung verteilt sind. Dies erfasst eine lokal gültige Repräsentation der psychischen Gesundheitsprobleme. Diese Studien wurden an zwei unterschiedlichen Orten in Mumbai durchgeführt. Die ethnografische Studie in Wohngebieten wurde im Elendsviertel Malavani, das 35 km nördlich vom Zentrum von Mumbai in der sogenannten „western suburb" liegt, durchgeführt. Die Studie über DSH wurde im KEM-Krankenhaus, dem größten Krankenhaus in

Mumbai, durchgeführt. Dies geschah in Zusammenarbeit mit Kollegen der Notfallstation, um so die systematische Überweisung aller Patienten, die den Kriterien der Studie entsprachen, sicherzustellen.

Die Forschungsarbeit, über welche in dieser Doktorarbeit berichtet wird, zeigt, wie kulturelle Epidemiologie, die durch Ethnografie gestützt wird, die psychiatrische Epidemiologie ergänzen kann, um klinische Praxis und die psychische Gesundheitspolitik anzuleiten. Unsere Studien in ihrer Gesamtheit weisen auf den Wert der ethnografischen Daten für die Identifizierung der Krankheitserfahrungen, der Bedeutungen und der Verhaltensmuster hin, welche die örtlich wichtigen Charakteristika von verbreiteten psychischen Gesundheitproblemen klarstellen. Die Forschung auf dem Gebiet des DSH untersuchte das Verhältnis zwischen den klinischen Diagnosen, welche auf den DSM-IV-Kriterien basierten, und den von Patienten wahrgenommenen Erklärungsfaktoren des suizidalen Verhaltens, welche in den EMIC-Interviews ermittelt wurden. Diese Perspektive hat ergänzende psychiatrische und kulturelle epidemiologische Beurteilung des suizidalen Verhaltens angeleitet. Örtlich relevante Eigenschaften, die auf die Auswirkung von Psychopathologie auf suizidales Verhalten achtet, zu Grunde liegende Probleme, welche die Patienten mit ihrer DSH in Verbindung bringen, und Stressfaktoren, die suizidales Verhalten auslösen können, sollten alle beachtet werden für die Prävention von Suizid, Interventionen zur Verbesserung der psychischen Gesundheit in der Bevölkerung und für die klinische Praxis.

Die hier präsentierte Forschung trägt zu einem neuen Ansatz bei, der geschlechts-sensibilisierte Informationen von praktischer Bedeutung liefert in Sachen Konzipieren von Dienstleistungen und Programmen in Stadtgebieten von einkommensschwachen Ländern.

Die Studien als einzelne und in ihrer Gesamtheit behandeln praktische und höchst relevante Themen, die von psychischer Gesundheitspolitik in Indiens Städten in Angriff genommen werden müssen, und zwar in Wohnquartieren und Kliniken der Armen und der Mittelklasse. Diese Doktorarbeit leistet einen Beitrag in Bezug auf psychischer Gesundheit in diesen Orten. Die Autorin hofft auch, dass das Beispiel von diesen Studien einen Ansatz für kulturelle epidemiologische Forschung verdeutlicht, der auch in anderen Situationen von Nutzen ist.

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Chapter 1

Introduction

Shubhangi R. Parkar

GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

The current progression of Urbanization is unprecedented, and it is expected to continue with dramatic effects on environments, societies, and people's well-being (Mezzich J.E. and Caracci G.C.,1999). Fifty years ago, less than 20% of the world's population lived in cities, but United Nations (2001) population projections now anticipate that by the year 2006, half the world's populations will be urban and 61% will be by the year 2025. The increasing proportion of urban to rural populations is most striking in Africa and Asia, and it is anticipated that in the next two decades 80% of the increase in urban populations will be in developing countries. In 1975 the world had only five megacities, that is, cities with populations of 10 million or more. By 2015, it is expected there will be 23 megacities, and all but four will be in developing countries. Mumbai, which now has a population of 16.4 million (Census of India, 2001) will then be the world's second largest city after Tokyo; three other cities in India (Kolkata, Delhi, and Hyderabad) and two more in South Asia (Dhaka and Karachi) will be among these megacities. By 2015 the world will have an estimated 564 cities with a population of 1 million or more and 425 (75%) are expected to be in developing countries.

In Latin America and the Caribbean, nearly three-quarters of the population are already urban which is comparable to rates in Europe, North America and other developed countries. In India, however, according to the 2001 census, 72.2% of the population are still rural (74.3% in 1991 and 76.7% in 1981), indicating a greater potential for sustaining the pace of increasing migration from rural areas into the cities. In the relatively prosperous state of Maharashtra, where Mumbai is the capital city, the pace of migration has been even faster. According to the 2001 census, 57.6% of the population is rural, compared with 61.3% and 65.0% in 1991 and 1981, respectively. In the decades from 1960 to 1990, it is estimated that 40% of urban

growth in developing countries, apart from China, came from inward migration and expanding urban boundaries, and 60% from natural growth of the existing population.

In Asia and Africa, these demographic shifts into cities have been especially challenging to efforts to meet the needs of the growing population, because population increases are largely among the urban poor (Bhattacharya, 2002). The combination and interactions of poverty and size are a far more formidable challenge than size alone. In Asia, Tokyo provides the example of the world's largest megacity with 28 million inhabitants, where, because of the availability of resources and planning, it is widely regarded to be a well-managed city. Tokyo has also been studied as a case study for modelling determinants of urban health to guide planning (Takeuchi et al., 1995).

While rapid urbanisation poses various threats to the environment and well-being of the population, the environmental and social impact of unbridled urban expansion on infrastructures that affect health status has made the topic a priority for public health, reflected in research and the establishment of programmes that recognise the particular considerations required for effective urban health planning. Inasmuch as urbanisation is also successful in fuelling industrialisation and development, the dynamics of the resulting epidemiological health transition introduce additional complexities for health planning in low-income countries, because in these settings the double burden of the non-communicable and chronic health problems of developed countries combine with the communicable disease burden of under-developed settings, and all of these take their toll (Harpham and Tanner, 1995). The urban poor are vulnerable to the adverse health effects and

suffering of both worlds, as new problems add to the existing burden that persists (Bradley et al., 1992).

Various studies in the last decade and a shift towards indicators of health status that are more sensitive to chronic, rather than mortal, disorders have emphasized the previously under-appreciated impact of mental health problems on the global burden of disease and disorder. Of the ten leading causes of disability affecting the adult population, five are mental health and behaviour-related problems in low- and middle-income countries (Murray and Lopez, 1996). The introduction and acceptance of the disability-adjusted life-year (DALY) as a more sensitive measure to this aspect of disease burden has contributed to the prominence of mental health on the international health agenda. Accounts of the need for attention to mental health as a growing problem typically refer to the influence of both urbanisation and the epidemiological health transition (WHO, 1991b; Philips, 1993; Editorial, 1994; Kleinman, 1991).

Analysing the contextual nature of mental health problems affecting low and middle-income countries, a Harvard University study leading to the publication of the *World Mental Health Report* in 1995 examined the role of social and economic conditions contributing to mental health problems; it emphasised the importance of formulating policy to address these issues in ways that acknowledge both professional psychiatric capabilities and local factors that shape problems, specific needs, and appropriate responses (Desjarlais et al., 1995). WHO's *World Health Report for 2001*, which focuses on mental health, (WHO, 2001a) and the WHO *Atlas of mental health resources* (WHO, 2001b) also emphasize the pressing needs for innovative policy, and they suggest a particular approach to formulating setting-specific policies to appropriately address mental health needs, based on the level of

development of countries seeking to enhance policy and programmes for mental health.

These accounts of the needs and approaches to achieving the mental health of populations highlight the broader social, cultural, and economic contexts, for which clinical experience alone is an inadequate guide. It cannot be assumed that policies derived from experience with middle-class populations of Western countries—or even middle-class populations of Asian and African countries—will be appropriate for guiding mental health policy needs to serve the residents of growing slums and shanty towns, where 30-60% of the urban population of low-income countries reside in dilapidated and inhuman conditions. The character of such slums highlights inequalities in access to resources of basic infrastructure, injustice, poverty, violence and crime. Evidence suggests that the vulnerability imposed by such conditions also imposes higher risk of psychiatric morbidity on the urban poor, exploited workers, illiterate men and women, the homeless, street children and the elderly (Almeida-Filho et al., 1992; Harpham, 1992; Mari, 1987).

There is also a positive side to urbanisation, however, although some authors have long questioned whether the virtues of megacities in developing countries have been exaggerated (Richardson, 1989). Cities are widely and in large measure correctly perceived as providing opportunities that are unavailable in the countryside. Despicable conditions that are anathema to the middle-class may nevertheless be considered preferable to rural alternatives for the residents—not because oppressive conditions are recognised as such, but rather because the alternatives are even more bleak. Cities are engines driving economic growth and development. The problems and the benefits of the inexorable process of urbanisation are contradictory, yet co-existing, realities.

Urban mental health problems

Considerable current research in psychiatry highlights the biological basis of mental disorders, based on criteria-based definitions of these disorders derived from clinical experience and research. The approach has been effective in contributing to the development of effective psychopharmacological treatments, but it also advocates a model of mental disorders that is less attentive to the impact of social conditions than many aspects of clinical practice and effective community mental health programmes require. As important and effective as advances in biological psychiatry have been, they are limited in their capacity to address many of the socially and environmentally engendered emotional problems and the kind of social suffering that has become a focus of interest in the field of cultural psychiatry. The kind of setting-specific policy and recognition of the contextual features of mental health problems that the *World Mental Health Report* and the WHO *World Health Report 2001* on mental health have advocated require other paradigms as a framework for research to guide them.

The field of cultural psychiatry has long been grappling with a tension between early psychiatric epidemiological study of mental disorders in Asia and Africa (Leighton et al., 1963; Beiser et al., 1972) in the context of transcultural psychiatry (Murphy, 1982), and questions about the limitations of dominant paradigms of psychiatry. The introduction of criteria-based diagnostic systems based on experience in Euro-American countries intensified these questions. The arguments were initially formulated in an effort to relate setting-specific and distinctive cultural features of the mental health problems encountered locally with

international psychiatry in the context of the so-called new cross-cultural psychiatry, originally advanced by Arthur Kleinman (1977; 1988).

In recent years with recognition of the substantial burden of mental illness, policymakers have suggested the importance of *mainstreaming* mental health, so that it may play a greater role in the national health planning strategies of low- and middle-income countries, where it still receives relatively less attention than the proportion of the disease burden might suggest it requires (Ustun, 2000). A persisting question, however, has been how to mainstream mental health without being constrained by mainstream biological models. The professional formulation of mental problems for psychiatric epidemiological study of mental disorders provides essential information required to set priorities and to examine the impact of interventions, but it may fail to address the perceived needs for promoting mental health in deprived communities with dramatic social and environmental sources of emotional suffering. The idea of what constitutes mental health problems for lay people and professionals may differ substantially, and careful attention to translating these concepts is required for the desired impact on the people requiring assistance.

Such concerns raise questions relevant to increasing interest in psychiatric epidemiology with questions about the validity of psychiatric disorders and their particular criteria-based formulations. (Regier et al., 1998). Reliability in assessing disorders is essential, but it is not a substitute for demonstrating the validity of those disorders with respect to professional action and local experience, meaning, and behaviour. The latter are also required to guide effective clinical and community mental health activities. An approach that recognises and integrates the complementary features of both global and local frameworks is needed to accomplish that (Weiss et al., 2001). Research on local concepts of mental health

problems is needed to complement psychiatric epidemiology, so that the languages and priorities of patients, communities and professionals may be mutually comprehensible.

Cultural epidemiology has been developing as an approach to providing an account and clarification of the distribution of local concepts that account for mental health problems with reference to patterns of distress (illness experience), perceived causes (meaning), and strategies for health seeking (behaviour) (Weiss, 2001). This research proceeds with a combination of ethnographic and epidemiological methods based on the cultural epidemiological framework and use of locally adapted EMIC interview (Weiss,1997). Ethnograhic research clarifies the contexts and categories for subsequent studies of the distribution of illness-related experience, meaning and behaviour. EMIC interviews are locally adapted to identify locally relevant categories of distress, perceived causes, and help seeking with reference to the problems of research interest and local cultural concepts of these conditions. The mental health problems that are the focus of research interest may be specified with reference not only to clinical disorders but also problems associated with mental health priorities apart from disorders, such as suicide and deliberate self-harm (DSH).

Gender and mental health

The interests of gender studies in mental health and psychiatry arose from attention to sex differences in the rates of various disorders and efforts to explain them with respect to biological and social contexts. Questions of gender, however, are enriched by careful consideration of the socially and culturally defined roles of men and women with respect to their self-image, families, and communities. Like culture itself, with which questions of gender are closely related, various aspects of

gender affect risk and vulnerability, access to care, and illness-related experience, meaning, and behaviour. Consequently, the interest in gender and its significance for health research extends well beyond questions of biological sex differences. Sex differences may serve as a starting point in addressing some questions, such as higher rates of depression and suicide attempts among women and higher rates of substance dependence and suicide among men (Robins and Regier, 1991). The basis for some of these sex differences in rates has raised many questions, for which needs for research are well-recognised (Thornley et al., 1991).

For some questions, it may be difficult to distinguish the significance of biological sex differences and socially based gender differences. For many issues of interest in mental health research and practice, however, the importance of considering the impact of social gender roles is clear. An integrated ethnographic and cultural epidemiological approach to research makes it possible to identify and examine essential features of gender that have a bearing on mental health. The social origin of psychiatric morbidity, which may be based on cultural values and features of social life, such as marital stress and devaluation of women, is a topic of particular importance. Various gender-specific ideas about interactions with the world outside the household and access to health care require attention. Questions about social acceptance and support, on the one hand, and disqualification from social acceptance, on the other hand may also arise with respect to various aspects of community life. This may either lead to mental health problems or provide supports that avert them, or which may also arise as social response to designated mental health problems when they do arise.

What this research is all about

The common theme linking the various studies that comprise this thesis has been research to examine local representations of various mental health problems in both clinic and community settings in urban Mumbai with particular attention to questions of gender. Designing this work to precede in both clinic and community settings provided valuable opportunities for examining questions and priorities for mental health interventions from vastly different perspectives. In the course of this research, I have relied heavily on my own clinical professional experience and personal experience of living in this city to select the particular themes of cultural context, gender and common mental health problems, on which the research has been based. I highlight the concept of “common mental health problems” in these studies because the nature of the problems that arise in the course of evaluating DSH and the issues that arise in dealing with both clinic patients and community residents are not restricted to the formal professional concepts of disorder.

If our clinical interventions and community programmes are to be effective, we must also consider the points of view of the people we are trying to assist. The professional evaluation remains relevant for many practical clinical and public health interests, but however important, it is a complementary orientation of evaluation that should be recognised as such. It is also useful to appreciate how people struggle to make sense of their suffering and illness, and the particular meaning these problems have for them in the contexts of their lives. Appreciation of the local cultural ideas and terms facilitates opportunities for translating professional concepts into terms that people understand, and for appreciating the needs that are locally formulated in ways that do not necessarily follow professional diagnostic groupings.

This research has been designed to be especially attentive to the urban context of social and cultural factors in Mumbai that affect mental health—factors such as economy, unemployment, poverty, and the cultural dynamics of family interactions. The nature and formulation of categories of distress, perceived causes, and help seeking were clarified in community dialogues through ethnographic community study and prior experience in clinical interactions employing the cultural epidemiological framework. A cultural epidemiology of mental health is an account of the distribution of the categories of experience, meaning and behaviour, which constitute locally valid representations of mental health problems.

These studies are presented in five chapters, which provide the background, methods, results, and discussion of complementary research activities. Each chapter is self-contained, but also complementary and indicative of the key features of cultural epidemiological study. The first of these research reports provides an ethnographic account of an urban slum community. The second chapter focuses this ethnography on identifying, specifying, and elaborating community concepts of mental health problems. Findings from the ethnography that specify categories of distress, meaning, and behaviour are applied in subsequently constructing an EMIC instrument that was used for clinical cultural epidemiological interviews with patients at the community primary health centre (PHC) in the slum community. The final two chapters report research on DSH that was carried out in an academic referral hospital situated in a middle-class community of central Mumbai. The first is a descriptive account of the cultural context of this problem comparing standard clinical assessments and findings from a cultural epidemiological study with an EMIC interview, which was designed for study of DSH and locally adapted for that setting. The next chapter reports findings from analysis of the role of gender in DSH from the

same study of these patients. Two common threads of interest link these chapters, namely, the focus on urban mental health issues and the cultural context of gender that relates social suffering to mental health problems.

Study sites

Figure 1.1. Map of greater metropolitan Mumbai showing Malavani community and KEM Hospital, Parel

These studies proceeded at two different sites (Figure 1.1). The ethnographic community study was undertaken in the Malavani slum, 35 kms north of Mumbai in a western suburb. The population of Malavani is approximately 150,000, and two-thirds of the population lives in an area officially recognised as a legitimate settlement. The remaining population lives in an area that is not officially recognised.

These are referred to as sanctioned and unsanctioned slums, respectively. The infrastructure of the Malavani community is characteristic of many slum communities, and it is complex, encompassing a wide range in the quality of housing and availability of resources and amenities. By and large, however, conditions such as access to potable water, sanitation, electricity, and other features of infrastructure range from basic or minimal to poor or totally lacking. The worst conditions are in the unsanctioned slums. The Malavani community is widely known in Mumbai for its criminal origins and considered an undesirable place to live, even among the poor.

The research was undertaken in connection with efforts implementing community mental health services and clinic services in a PHC that has been staffed by personnel from the KEM Hospital in central Mumbai. A motivation for the study was to guide the development of these clinic-based services and community activities that would be response to needs of the residents. The PHC of Malavani was the research site for the clinical cultural epidemiological study of common mental health problems among patients who came for treatment in the medical outpatient clinic and were screened positive with a screening questionnaire.

The KEM Hospital is the largest hospital in Mumbai. The study of DSH was based in the department of psychiatry, and it proceeded in cooperation with a network of colleagues in the emergency medical department to ensure systematic referrals of all patients who met criteria for study. The department of psychiatry has a long-standing interest in suicide and DSH, and this study was undertaken to identify the particular needs of patients and to develop effective interventions for treating such patients through applications of the EMIC framework. It also aimed to acquire insights that would be useful for community-based suicide prevention activities.

Overview of Methods

These studies employed ethnographic field research methods in the Malavani community; they used EMIC interviews to study 120 patients with common mental health problems in the Malavani PHC and EMIC interviews to study 196 patients after admission for DSH at the KEM Hospital in central Mumbai. The ethnographic phase of research was undertaken to provide an account of the Malavani community with particular emphasis on those aspects pertinent to emotional distress and mental health. It involved a period of participant observation and extended interactions with local residents and community groups. Qualitative and participatory methods involved in-depth interviews, key informants and focus group discussions. Participatory interactions with women's groups were undertaken to identify service needs and to formulate strategies to respond, based on aims for the community mental health programme to develop participatory approaches that would enhance a community-based service programme to follow the research.

Findings from the ethnographic phase were also incorporated into the construction of the EMIC interview that was used for studying common mental health problems in the PHC. The EMIC interviews for DSH were specially adapted to address aspects of experience, meaning and behaviour of both the self-harm event and the underlying problems that patients identified as playing a role leading to that event. Questions about the gender basis of community life, the mental health problems of the PHC patients and the DSH patients at KEM were incorporated into the agenda for ethnographic research and all the EMIC research instruments. For the EMIC studies, patients were interviewed with standard diagnostic (Structured Clinical Interview for DSM-IV, SCID) and assessment instruments (Hamilton Depression and Anxiety Rating Scales, HDARS) to facilitate analysis relating the

cultural epidemiological representations of illness with professional psychiatric representations of illness, that is, diagnostic categories and the magnitude of depressive and anxiety symptomatology. Further details concerning research methods are presented in each chapter.

Chapter 2: Contextualizing mental health: gendered experiences in a Mumbai slum

Aiming to identify the environmental, social, and cultural underpinnings of community life in this slum, research reported in this chapter examined historical documents and public records concerning the foundation of the Malavani community and relevant health-related data available through the PHC. An agenda for this ethnographic field research was prepared, and it highlighted the particular social roles and cultural expectations of men and women to elaborate the context of gender. Findings provide an account of background data on the historical origins of Malavani, but they focus primarily on life in the community with reference stressors and supports pertinent to emotional distress and mental health problems. The account of living conditions, their impact, and the thematic structure of their daily lives are based on the residents' views.

Chapter 3: Ethnography of common mental health problem in an urban slum community

Research reported in this chapter provides an account of that aspect of the ethnographic study focussing on the local formulation of mental health problems from the community perspective. We were especially interested in what people identified as common mental health problems, how they understood these problems, and what they did about them. We expected that findings would help translate the

nature of problems that would improve the quality and value of the interactions between clinic workers at the PHC and field staff in community who routinely interact with patients and residents.

Our approach followed the guidelines of community ethnographic research employing multiple methods and a focused agenda, which had been developed in a previous cultural epidemiological mental health study in the Sunderban delta, a rural region of West Bengal (Chowdhury, et al., 2001). We adapted this approach for our research in Malavani. The agenda was designed to follow the EMIC format to ensure that relevant background data would be available to construct the EMIC interviews subsequently. The agenda also addressed broader issues of the community structure and institutions that contributed to our appreciation of the context, but which were not necessarily intended to be included in the EMIC interview.

Chapter 4: Clinical cultural epidemiology of common mental disorders with reference to gender in a primary health centre of an urban slum

Research with the EMIC examined the cultural epidemiology and gender-related features of common mental health problems among patients screened positive for a clinical psychiatric problem with the 20-item Self Report Questionnaire (SRQ). Clinical and cultural study examined patterns of distress, perceived causes, and prior help-seeking behaviour of patients who came to the Malavani PHC for treatment. SCID diagnostic interviews provided a psychiatric diagnosis based on DSM-IV criteria, and assessment with the Hamilton Depression and Anxiety Scale indicated the magnitude of specific psychopathology. By employing both clinical and EMIC assessments, the analysis could identify the varieties and distribution of categories of experience, meaning, and behaviour associated with particular clinical

disorders in this setting. The narrative accounts and qualitative data from studying these patients made it possible to clarify the nature and implications of the categories noted in the interview.

Chapter 5: Clinical and socio-cultural dimensions of deliberate self-harm in Mumbai, India

Suicide is a priority mental health problem for which many prevention strategies based on screening for high-risk disorders in the community have not fulfilled expectations. This study was designed to characterise the features of DSH that might provide a better understanding of the contexts and motivations for the self-harm, extending the scope of the inquiry beyond the diagnostic profile of patients. Surveillance data for suicides maintained by the Government of India suggest that official statistics attribute relatively few suicides to psychiatric disorders (only 4.6% in the category of "insanity" and no other related categories). Although psychopathology undoubtedly plays a greater role, the low figure reflects the design of the classification scheme, available categories for record keeping and the nature of the reporting process. It highlights the difficulty in providing an adequate and useful account of the context of suicide, which acknowledges the difficulty (and perhaps the folly) of attempting to assign a single cause.

Perhaps reflecting an antithetical bias, clinical and epidemiological accounts of suicide and DSH typically focus on psychopathology and give low priority for consideration of the social and cultural contexts of DSH. The study reported here examined the cultural experience, meaning and behaviour accounting for the DSH event and the underlying problems among patients admitted to the KEM Hospital in Mumbai. It identified their cultural epidemiological features, namely, pattern of

distress, perceived causes and help seeking practices. The study also examined the relationship between psychiatric clinical assessment of psychopathology and findings from assessment of DSH with an EMIC interview.

Chapter 6: Cultural epidemiology of deliberate self-harm and the role of gender in Mumbai

In this chapter, we report findings from an analysis of gender in the cultural epidemiological study of patients admitted after DSH from the same sample as in the previous report. Family dynamics (e.g., in-law conflicts), social expectations (e.g., unemployment and joblessness), and other social stressors were expected to play important and fundamental roles in the accounts of men and women, but in gender-specific ways. This analysis also compared the EMIC data and diagnostic profiles with respect to sex differences, and it analysed the qualitative features of the categories with particular attention to the indicated role of gender. Together, findings from this and the previous chapter were expected to provide additional information about the basis and context of DSH and suicide, which would be applicable in clinical practice and community prevention programmes.

Chapter 7: Summary and conclusions: Implications for clinical practice and mental health policy

The thesis concludes with a discussion summarising key findings and their implications from consideration of research experience and findings across all of the reported studies. It also discusses the complementary nature of psychiatric and cultural epidemiological research orientations. Neither is wholly satisfactory without consideration of the other. Similarly, our focus on the social and cultural contexts of

suffering is intended to complement, but not replace, biological accounts and treatment of psychiatric disorders. In that respect, it aims to redress an imbalance that is especially critical for meeting the challenges of urban mental health; too often vital social and cultural contexts have been ignored, and this has made it difficult for community mental health programmes to be regarded locally as relevant to communities' perceived needs.

The research reported in this thesis contributes to a novel approach that provides gender-sensitive information of practical significance for designing services and programmes in urban settings of low-income countries. Individually and collectively, these studies are addressing practical and highly relevant issues that mental health policy must address in India's largest city, both in both community and clinic settings of a slum and a middle-class neighbourhood. In addition to their contribution to mental health at these sites, it is hoped that the example of these studies will also clarify an approach to cultural epidemiological research that will be useful in other settings.

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Chapter 2

Contextualizing mental health: gendered experiences in a Mumbai slum

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GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

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Contextualizing mental health: gendered experiences in a Mumbai slum

Abstract

Urban mental health programmes in developing countries remain in their infancy. To serve low-income communities, research needs to consider the impact of common life experience in slums, including poverty, bad living conditions, unemployment, and crowding. Our study in the Malavani slum of Mumbai examines afflictions of the city affecting the emotional well-being and mental health of women and men with respect to gender. This is a topic for which mental health studies have been lacking, and for which psychiatric assumptions based on middle-class clinical experience may be most tenuous. This study employs ethnographic methods to show how environmental and social contexts interact in shaping local experience with reference to common mental health problems. Focusing on the social and environmental context of the mental health of communities, rather than psychiatric disorders affecting individuals, findings are broadly applicable and sorely needed to guide the development of locally appropriate community mental health programmes. Identified afflictions affecting mental health include not only access to health care, but also sanitation, addictions, criminality, domestic violence, and the so-called bar-girl culture. Although effective clinical interventions are required for mental health services to treat psychiatric disorders, they cannot directly affect the conditions of urban slums that impair mental health.

Introduction

In Mumbai, India's largest city with an estimated population of 16,360,000 (Census of India, 2001), 60% of the people live in dilapidated areas, communities whose residents routinely contend with serious economic hardships and constricted opportunities. The Indian government refers to such an area as a 'slum', a label which is intended to identify communities in need of support, but may paradoxically and unintentionally fix identities in ways that deny, rather than afford, opportunities for urban development. Characterizing a community as a slum may identify it with chaos and squalor. It may also mark the people who reside there as dirty and chaotic, inappropriately confusing their disadvantaged status with an unshakeable feature of their identity—a mark of stigma and a source of shame.

Some social commentators in India, however, have suggested an alternative to this middle-class interpretation of slum, noting that they are not just hotbeds of problems, but also places where millions of rural poor have flooded into cities to take advantage of opportunities for work, higher income, education, health-care facilities, and entertainment. Cities rely on the labour of these slum residents to work the factories, drive the taxis and rickshaws, and to work as servants to care for the families of the middle class. Recognizing they provide economic opportunity and opposing the wave of slum demolition for urban renewal in Mumbai in the late 1980s, critics of the mainstream view argued that although we need to improve conditions in the slums, we nevertheless need more slums (Aiyar, 1988).

Similar accounts that emphasize either positive or negative features of slums have been reported from many parts of the world (Lloyd, 1979; Gilbert & Gugler, 1994). The concept of 'slum' itself is vague and ambiguous. The Penguin Dictionary of Geography defines a slum as "a rundown settlement or part of a settlement,

usually in or near an urban area and characterized by dilapidated buildings or shacks, the poverty of its inhabitants, squalor, the presence of refuse and overpopulation" (Clark, 1998). Outsiders commonly have low regard for slums, considering them to be dirty, dangerous places where uneducated, criminal, and alcoholic people reside.

Among research efforts to serve development interests in the mid-1990s, Harpham (1994) and Harpham and Blue (1995) put 'mental health' on the agenda of urban health studies. Based on a broad review of the literature, they emphasized the role of social factors contributing to urban mental health problems through increased stressors, such as overcrowding, pollution, and limited social supports resulting from breakdown of extended families and disrupted traditional networks. Over the past decade, recognition of the need to examine the impact of poverty on mental health has received increased attention, acknowledging the effects of bad living conditions, unemployment, crowding and congestion on both physical and mental health (Desjarlais et al., 1995; WHO, 2001).

Social roles defined by gender influence this vulnerability, and a gender-focused analysis and study of mental health in slum communities can be expected to clarify how women and men experience physical and social environments affecting their emotional life. These effects are mediated by gender in various ways, for instance, as devaluation of women's needs and abilities, unequal social status, marital stress, housing conditions, and both gender-based and other life events (Chakraborty, 1990; Abas & Broadhead, 1997; Davar, 1999).

Aims and objectives

In this article, we present findings from a study which contextualizes common mental health problems in an urban slum of Mumbai. By focusing on conditions of a slum community, we address a segment of the urban population for which mental health studies are lacking, and for which the assumptions from middle-class clinical experience may be most tenuous. What are the links that men and women in this community see between their well-being or distress and the urban environment? How do concepts of mental health problems relate to these environmental and social afflictions of life in the slum? By investigating such questions in a particular locality, this research aims to contribute to the growing interest in the community contexts of mental health with reference to population health and mental health promotion (WHO, 2002; Friedman & Starfield, 2003; Kickbusch, 2003; Kindig & Stoddart, 2003).

Main features of life in Malavani

The area called Malavani, situated 35 km north of central Mumbai in a Western suburb, is a representative slum. Its population is approximately 150,000, and the residential area includes two distinctive types of settlements: recognized (or legalized) areas and illegal settlements, which we refer to as sanctioned and unsanctioned slums, respectively. The infrastructure for all of Malavani, by and large, is very poor, lacking basic amenities such as clean water and satisfactory sanitation, and the worst conditions are in the unsanctioned slums (Figure2.1). Historically, this community has been identified with criminal elements, and this further contributes to its identity as a culturally undesirable place to live.

Figure 2.1: Streets in an unsanctioned colony of Malavani during a lull in monsoon rains.

Methods

The bulk of this study was carried out from 2000 to 2001; and research in this community continues. Various ethnographic methods were used. Participant observation at the outset was especially important to clarify the nature of life and culture in this slum, and the routine behaviors and social interactions. Com-munity-based fieldwork included in-depth interviews with key informants and residents of the community, focus group discussions, other informal group discussions, and participatory methods. The agenda for the interviews and focus groups was developed from consultation with community action facilitators working in Malavani and from discussion with staff of the primary health centre serving the community. Interviews with long-term residents were conducted in selected, representative sections of Malavani.

Among the 28 in-depth interviews, 10 were with men and 18 with women. The women were mainly housewives from different parts of Malavani slum (sanctioned and unsanctioned), four were community health workers, and three women were socially active in community development activities. Men were from various social, religious, and occupational groups, including some with government jobs, unemployed young men, and community leaders. Six focus groups were organized to ensure representation of both sexes in sanctioned and unsanctioned areas. Most of these adults had lived in their respective communities for five to 15 years. Focus group discussions (FGDs) were conducted with men and women, one each in sanctioned and unsanctioned areas, and a third focus group in each area was conducted with adolescent boys and girls who were born and raised in Malavani. Older focus group participants and interview respondents provided a historical account, from the origins of the community to the present, highlighting significant developments and changes in the community life of Malavani.

The research team consisted of a community social worker and medical doctors (including the first author, a consultant psychiatrist, and resident trainees in psychiatry). In addition to the interviews and FGDs, information about the history of settlement, population data and socio-economic status was collected from official records of the primary health centre and health posts, and from records of the Mumbai Municipal Corporation. In the following sections, which include illustrative narrative accounts of community life, pseudonyms have been used to protect the identity of respondents.

A specific agenda guided interviews with individual respondents and FGDs. This agenda considered stressful and supportive features of community life with particular attention to gender context. To begin with, general aspects of life in the

community were discussed, considering problems and concerns with respect to infrastructure and basic amenities, general environment and facilities. Many issues such as unequal distribution of basic amenities, demolition of unsanctioned housing, homelessness, criminality and negative social labelling were elaborated. Various aspects of men's and women's roles with respect to jobs, unemployment, social interactions in the community were examined. Common themes—including addictions, domestic violence and marital problems—emerged spontaneously in the course of these discussions. Women's FGDs emphasized the pressure on women to earn, domestic violence and the impact on them of alcoholism among men. In the privacy of individual interviews, women reported personal accounts of marital problems and victimization. Men's FGDs emphasized a lack of opportunity, joblessness and environmental problems.

Results

Main causes of common mental health problems

Various environmental and infrastructural problems that affect everyone in Malavani are summarized in Table 2.1, which indicates the experience and mental health implications of these problems for the community population. Because of widely held ideas about Malavani, migration into this community itself commonly generated feelings of demoralization and hopelessness. Water, electricity and toilet facilities were scarce, even in the government-sanctioned plots, but worse in unsanctioned areas where stealing water and electricity with illegal connections is very common. The cost of electricity, water, and the use of toilets is a heavy burden for many Malavani residents. FGDs elaborated the unequal distribution of basic amenities and how this led to hostility and conflicts. Because it is official government

policy to clear unsanctioned slums every six to eight months, many residents live with a persisting threat of demolition and homelessness. Criminal violence is also a major concern. Petty crimes appeared to be associated with the expansion of Malavani and the proliferation of the unsanctioned slums, unemployment, and addictions and problem use of alcohol and drugs.

Table 2.1: Impact of urban afflictions affecting everyone

Problems	Experience	Implications for mental health
Migration and displacement to slum	• Decline in social status • Restricted opportunities • Broken social and cultural ties	• Hopelessness, disappointment, and demoralization • Addictions
Poor infrastructure and bad living conditions	• Routine hassles and hardships • Compromised living styles	• Deterioration in quality of life • Adjustment problems with emotional distress
Unequal distribution of basic amenities	• Perceived injustice • Rivalry, disharmony, and conflict	• Instability • Hostility and violence • Criminality
Demolition of housing and homelessness	• Persistent insecurity, instability • Feeling of discrimination • Social instability	• Emotional distress • Depression • Anger and hostility
Communal and ethnic disharmony	• Poor interpersonal and social relationships • Community violence	• Aggression and violence • Depression

Source: Field research, 2000–2001.

In the interviews and FGDs, men and women identified various interrelated social afflictions affecting the mental health of both sexes in different ways. Tables 2.2 and 2.3 summarize these problems, including economic insecurity, problem use of alcohol and drugs, violence, strained marital relations, and so forth.

Table 2.2: Impact of urban afflictions mainly affecting men

Problems	Experience	Implications for mental health
Economic insecurity	• Unemployment and underemployment • Lack of family income • Lack of meaning and purpose • Apprehension about future	• Insecurity and lack of motivation • Learned helplessness • Criminality • Frustration, aggression • Domestic violence

Problems	Experience	Implications for mental health
Substance abuse and dependence	• Economic hardships • Stressful lifestyles • Disturbed social relationships	• Rejection, hostility • Antisocial behavior • Domestic violence • Depression
Violence	• Interpersonal and social conflicts • Gang violence	• Hostility and aggression deterioration in quality of life
Polygamy and extramarital relations	• Disregard for marital and family responsibilities • Disruption in cultural values • Diminished social standing	• Emotional distress • Alienated social networks • Marital discord and disrupted family life

Source: Field research, 2000–2001.

Table 2.3: Impact of urban afflictions mainly affecting women

Problems	Experience	Implications for mental health
Employment of women	• Dual responsibilities of home and work • Substandard jobs and pay • Sexual exploitation	• Fatigue and weakness • Low self-esteem from menial position • Depression, emotional distress
Polygamy and infidelity	• Marital disharmony • Abandonment • Exploitation of women • Domestic violence	• Emotional distress, • worthlessness, depression • Deliberate self-harm and suicide
Domestic violence	• Family disharmony • Marital disharmony • Humiliation of women	• Shame, helplessness, humiliation • Depression • Deliberate self-harm
Inter-religious and inter-caste marriages	• In-law and household conflict • Exploitation • Abandonment • Homelessness	• Devaluation, loss of self esteem • Deliberate self-harm and suicide
Alcoholic husbands	• Domestic violence • Economic hardship • Marital discord	• Anger and hostility • Devaluation, diminished self-esteem • Depression and suicide

Source: Field research, 2000–2001.

Economic insecurity

Unemployment and underemployment of men is regarded as a major problem (Table 2.2). Because finding work may often require a bribe, money is required to

make money. Hoping to find work in day labour, men congregate in areas where they are most likely to get such work, such as at the Malad railway station. They take whatever diverse small jobs may be available, such as helping to paint a house, construction, carpentry, and labour with contractors. Other men make a living self-employed as hawkers selling small items, driving rickshaws, working in grocery shops, or selling betel and tobacco (pan and bidis).

Some men who cannot get such work settle into a pattern of unemployment, which becomes troublesome for them and their families. After repeated unsuccessful efforts seeking work, the men may develop a sense of helplessness and become accustomed to sitting idly.

Sumantai, a female resident community worker with the research group, explained the emotional turmoil resulting from unemployment that affected her husband's mental health as follows:

> He brought us to Mumbai to earn a livelihood as we were facing problems in our village from drought. Many men moved out to Mumbai with their families. We came and settled in Malavani with others. He soon got frustrated here, as he was not able to earn despite trying hard. Initially he stopped socializing with other people from the village due to shame, and he complained of 'tension'. Slowly, he started drinking alcohol because of feeling tense. When I started working as a domestic servant, he initially hated to survive on my income. He used to become hostile and leave the house for the whole day, spending his time with other unemployed (bekar) individuals in the community, returning home very late. Today after 10–12 years of being in Malavani he is an

alcoholic. He doesn't even try to earn or to look for a job.

Some men appear unconcerned about unemployment, comfortably accepting their wives working and providing the family income. When asked about this pattern, a man explained, "*It is quite normal in the city like this where women are working, because men don't get jobs. So what? Even children are working and earning. Looking after and taking care of the family is a women's job; she needs to help her husband in difficult times*." More typically, however, men and women in FGDs discussed repugnant effects of unemployment. They referred to some examples of men staying with other women for sexual enjoyment while harassing their working wives for money and to maintain the household.

Regardless of what men might think of their unemployment, it took a toll on the mental and emotional state of their wives and children. One woman described her irritation and helplessness with her husband, explaining that she had been trying to find a job for him, but no matter what turned up, he refused it on one pretext or another. The distinction between whether he could not or would not find work became difficult to make. "*Poverty is a problem*", she explained, "*but it creates more tension for women. These men always say they can't work, but they don't even try. When we try to arrange for a job they immediately decline the offer. Now these men have got the idea of keeping bar-girls so they don't have to work*."

Because many men either have no jobs or cannot earn enough, about 60% of the women in both sanctioned and unsanctioned slum areas are working at paying jobs. Jobs available to these women are typically menial, often positions as domestic servants, minding children in a kindergarten (*balwadi*), or as labourers at construction sites. Some sell fruits, vegetables, or cooked snacks, either circulating on foot or sitting in a market. Younger women with some education may work as

salesgirls in the city, even in the better shops. Some stitch clothes, embroider, or work as packers in the shops. We encountered some women who had taken up their husband’s work as hawkers, selling various items or providing services on the footpath. Some women pursued unexpected occupations inconsistent with gender-based expectations, such as the woman in Figure 2.2 working as a cobbler. Still other women found jobs as bar-girls, selling drinks and dancing for men, and for many of them, this entailed at least part-time work as prostitutes.

Figure 2.2: Woman working with her husband as cobbler.

Their ability to work and earn when men cannot is a distinctive feature of the urban experience of Malavani women. Nevertheless, their capacity to earn money outside the home does not necessarily bring the right to manage this money in the home. Even among those women who do manage their earnings, it is often with limited autonomy. Women who are earning are expected to give this money to their husbands or fathers. Despite earning enough, they may still lack sufficient funds to purchase essential household supplies.

Addictive and problem use of alcohol and drugs

Dependence on tobacco—smoked and chewed—and alcohol is very common among men in Malavani (Table 2.2). Many respondents identified this as the root cause of various social problems, especially criminality and domestic violence, which are rampant in the community. According to FGD estimates, alcoholism is a problem affecting 60–70% of the male population, and if additional drugs like cannabis are counted, problem drug use affects an estimated 75–85%. According to most of the male respondents from focus groups and in individual interviews, addiction to brown sugar (a preparation of heroin that is smoked) is now less of a problem than 10 years ago. It has decreased as a result of growing public awareness of its effects and because of its cost. Alcohol is distilled locally in hutments, called *hatbhatti*, and is readily available. We also met a few women who sell liquor to regular consumers. Alcohol may be sold on credit (*udhari*) as the person drinks. At some point, however, the drinkers are required to pay, or they will get no more, or they may be threatened if the don't pay. As the pressure builds, these men may get the money from their wives, from pick pocketing, other petty crime, or from begging if they must. Both women and men attributed much of the violence and antisocial behaviour in the community to such behaviours of alcoholic men.

Male and female participants in FGDs explained that alcohol and drug use is an expression of frustration by men from unemployment and financial insecurity. Women with alcoholic husbands and children also blamed the addiction-prone environment in Malavani. One woman respondent who lost her husband due to alcoholism, and who also had an alcoholic son, explained, "*The community definitely plays a role. All drugs are easily available, and people openly consume drugs here. Living in this place is itself a tension*."

A 41-year-old male addict explained in detail how as a very young boy he began drinking and then deteriorated socially. He emphasized peer pressure and the addictive surroundings of Malavani among the main reasons for his becoming addicted:

> I became an addict because of Malavani. In other places I would not have done that. I came to Malavani at age 11 with my mother from Bihar. As my mother went outside to earn daily, I started smoking cigarettes and occasionally drinking alcohol with bad friends. Everybody was so open about drinking and smoking. Nobody objected, since people have accepted these habits as routine. They introduced me to brown sugar, which first came to Malavani in the 1980s. I was not aware of the ill effects of this drug until I was totally addicted to it. When my consumption increased, there was no money left, so I started pick pocketing and carried on with petty theft. My mother left me and went back to Bihar. I was all alone, tense and frustrated. No support and no one to turn to—no money. Now I am dying without food and medicine.

FGDs elaborated conditions and the atmosphere in Malavani that is conducive to drug addiction. The drugs are available in the community because so many people sell these drugs to earn easy money. Many women respondents regarded alcoholics as emotionally unstable and uncontrollable. When asked, they did not regard dependence on alcohol and drugs as a mental health problem. They typically considered it more of a social problem affecting irresponsible and unemployed (*bekar*) people. They explained that addiction of any sort started as a habit to deal with tension, and it becomes a problem under the influence of bad

people in the community. They also linked the condition with tension from unemployment and poverty. Women addicts were mainly identified as bar-girls who either smoke, drink alcohol or take opium. Such women were considered ‘bad’. *“These women are bad characters who are spoiling the young generation by hooking them. They should be thrown out of the community.*”

Degenerate and diverse character of men

An elderly Muslim faith healer gave a scathing account that summarized the overall impact of widespread unemployment, addictions, infidelity and domestic violence on the character of Malavani men:

> The men of Malavani are frustrated and characterless people. They don’t work, they don’t earn, and they sit the whole day on their beds. If women earn because the husband doesn’t have a job, that is okay since there is no choice. But the man should at least value her contribution. These men are big tensions for the women. They are not faithful; they abandon them for other women. Sometimes they are married twice, and they expect the wife who is earning to take care of the other woman. They beat them badly and humiliate them every day. They even harass their wives for the money they want to give to other women and bar-girls. Today they even keep bar-girls for easy money, or they ask their wives to be bar-girl.

Although such derisive views were widespread, they were not uniform, and we also heard positive accounts. One woman related her story in an FGD of how her life was transformed from a hell (narak) to heaven (swarag) when her husband

renounced alcohol and committed himself to the principles of Buddhism. Her husband became a responsible wage-earner, looked after the children and spent time with the family. "*It was more than I could have asked for.*" Some religious groups and community organizations have targeted alcohol problems and family values for community intervention.

Violence

Violence is a pervasive experience in Malavani with distinctive effects on men and women. Various types of violent conflict may be identified—that is, fighting between individuals, between different colonies and gangs, or between different ethnic or religious groups. In view of scant resources, it is understandable that quarrels among these groups often develop over practical concerns, such as where to leave garbage, get water, and rights to use toilets (where available) and areas for defecation. The quarrels that are a part of daily life may escalate and lead to violence. They may also become a focus of gang fights. Many of these conflicts arise from long-term antagonisms, land disputes, or in response to larger events that lead to mob violence. Community tensions also exist between residents of the sanctioned and the unsanctioned slum colonies, arising from the unequal distribution of basic amenities; one group may try to appropriate electricity, water, and even the toilets of another. Communal tensions between Hindus and Muslims, usually dormant, may suddenly ignite over seemingly trivial disputes or political issues. As in other sections of Mumbai, some of our informants advised that such communal conflict is a product of the last decade, and that there was very little communal discord in Malavani before the riots of 1992–1993, following the destruction of the Babri Masjid in Ayodhya on 6 December 1992.

Domestic violence is a common daily experience. Husbands beat their wives, and mothers in turn beat their children. The women we spoke with suggested that 60–70% of all women in Malavani routinely endure some degree of domestic violence. Nearly all the women in our focus groups reported having been beaten at one time or another, and according to them, nearly every household had its own story of drunkards and domestic violence. When discussing the frequency and the consequences of such experiences, they described a pattern of domestic violence, humiliation and frustration, and their accounts of these household stories suggested to them that suicide was the only alternative to the misery of such conditions.

The extent of domestic violence that was widely reported by men and women respondents was also supported by evidence from clinical experience in the PHC. We saw wounds and fractures that many patients accounted for as the result of physical abuse. Most respondents in the focus groups regarded such violence as a part of normal life, especially when men are unemployed, drinking or have more than one wife. Some people suggested that this happens rarely in educated families, or when the men are in good spirits, have acceptable jobs and enough money.

As they became more reliant on the earnings of their women, men seem to give greater priority to controlling them. One man, for example, who earned nothing in the past 18 years, continued to live with his wife and beat her regularly and severely. He said that his wife was responsible for the beating because she provoked him by speaking arrogantly and not doing her housework properly. He explained, "*She has to be kept under control. She thinks too much of herself because she is earning these pennies for us.*"

In the focus group discussions, many women agreed that physical abuse resulted when men became accustomed to sitting idly without responsibilities. Some

women argued that living far away from their cultural roots, these men were uninhibited about responding to every impulse. There was no moderating influence of elders to whom they must answer or who might challenge their conscience and admonish them for unruly behaviour. Others mentioned that men are influenced by their peers who also abuse their wives and families. Several women reported that men were highly suspicious of their wives and daughters, not wanting them to speak to other men, or even to other women, because these men feared their women might be talking about them and plotting against them. Some men kept detailed accounts of their women's time outside the house for marketing or anything else, including visits to the doctor.

Women from the sanctioned colonies and from the better-off Muslim families were more likely to be tolerant of domestic violence. As one of them explained in an FGD, a woman who gets everything she needs from her husband should not mind if he beats her. She told us, "*There is no insult if your own man beats you. It is his right to do so; our men also have various tensions of running a family, earning money. Where else will he remove his frustrations?"* Several also acknowledged that women must tolerate at least that much to forestall abandonment and to discourage their husbands from taking additional wives.

Women who did not share this view felt there was little they could do about it; there was no way out and no chance for social justice. So long as they were compelled to live with the men who beat them, the legal system could not help. Occasionally a local women's group might try to help, but at best with mixed results. They explained that women who tried to help others might themselves be at risk, and they become targets of abuse from their own husbands.

Accounts were not uniformly hopeless, however, and we heard of some successful interventions. Socially aware and active women had formed a local-group to protest wife beating and to prevent men from deserting their wives. They had approached local leaders for help, and police when needed, and they persuaded alcoholic husbands to get treatment. One of the women in that group was also working with the research team.

Strained marital relations

In the FGDs, women recounted a steady flow of stories about marriage and married life. They attributed many of their tribulations in Malavani to changing features of the culture, a more open society and loss of traditional family values, which were all attributed to the influence of city life. Although some women from the sanctioned colonies enjoyed a relatively better lifestyle, their stories were also filled with pathos, despair, humiliation, and struggle for survival.

One woman told us that she didn't know whether the man who brought her as a child from North India to Malavani was her father or not. He had sold her as a young girl, 11 or 12 years old, into marriage and disappeared, which led her to question whether it could really have been her father who had done that. She described her experience as a new way of pushing young girls into prostitution, sanctioned under the guise of marriage to make it legitimate. She explained how many poor young girls are brought from different parts of the country to become bar-girls or to be sold into prostitution. Sometimes they come with marriage proposals, or they are purchased from their relatives, and some are simply kidnapped. The weight of resentment from such harsh treatment was clear as these women recounted their personal histories.

Some women felt badly cheated, especially those who had been brought to Malavani from a village in another part of the country. These rural women did not have any inkling of what was in store for them. Life in the city that awaited them was far different from what they had heard about Mumbai, and perhaps seen in films—a city that was supposed to be a wonderful and exciting place. They expected modern amenities and relief from the drudgery of the farm work they had endured in their villages. One of these women explained her disappointment after living 10 years in Malavani:

> The slum is more troublesome for women in every way. You are not secure in a place like this, not physically or otherwise. Thank god I don't have a daughter. If I did, I would not have stayed. I would have gone back to UP (Uttar Pradesh).

Although many older women resented the ordeals they routinely endured and their inferior status, they lacked confidence in their ability to do anything about it. They explained that it was necessary to submit to such violence and to accept a system controlled by men. Others felt that education and economic autonomy provided some hope of a way out. This view was expressed mainly by younger women in the focus groups. Those with exceptional opportunities, who were earning or going to college were most likely to argue that women need to speak up and claim more than they were offered. In today's world, they said, the capacities of women are in no way different from those of men. Most of them agreed, however, that men do not want them to be independent or to gain power. The president of the local women's group (*Mahila Mandal*) told us,

> I cannot take too many decisions about what I cook in the house. I cannot go anywhere without asking my husband. In our slum it will be

> discussed if I don't tell my husband. People will criticize and say I am on the wrong path. Men may become suspicious about our activities.

Most women in Malavani are illiterate or have no more than some primary education. Very few, according to the PHC records, have reached beyond the 8th standard. As some women explained, there was no question of schooling for those girls who were overtly exploited, inasmuch as no one typically indicated any interest in their welfare. Some families, however, allowed their daughters to pursue advanced education, but they feared that the girls would become more vulnerable, rather than resilient, to threats of exploitation. They were concerned that 'urban ways', as reflected in Hindi films, might lure girls into recklessness and irresponsible relationships with boys that could too easily spoil their lives. We heard stories of girls who had run off with boys, and it was clearly understood that these girls had been exploited. Few girls had the opportunity to go to high school or college; instead, they were encouraged or compelled to marry. In focus group discussions, adolescents agreed that education was less of a priority for girls than for boys. Moreover, girls were expected to assist their mothers in housework and child care, not to do homework for school and prepare for examinations.

Inter-religious and inter-caste marriages are matters of increasing concern for women. Many examples indicated the problems resulting from romance and mixed marriages, including cases of attempted suicide. Marital relations typically became strained as the romance faded, and when the boy's parents in the joint family began to treat the girl harshly and disdainfully. There were stories of families evicting the daughter-in-law, and leaving her to fend for herself. Such women were seen as particularly vulnerable to exploitation. Because they needed some job and income to

ward off homelessness and destitution, they were likely to become bar-girls or prostitutes.

Vocabulary and syntax of mental health problems

Among the various terms that are used to characterize the stressors and distress of life in this slum community, narrative accounts emphasized the concept of tension; this term was most pervasive and important. Tension refers to a broad range of subjective distress, which may coincide with common psychiatric disorders (anxiety and depression) but goes well beyond that. Even when people suffering from tension do not meet formal criteria for a diagnosis, the impact of tension may nevertheless be severe, and it may lead to suicidal and addictive behaviors. The taxonomy of tension is specified by its various sources: husband tension, children tension, financial tension, in-law tension, work tension, water tension, and so forth. Tension is the language through which the people articulated the emotional impact of the environmental and the social experience of the slums.

Discussion

Our findings demonstrate the substantial impact of environmental and social settings on emotional life and mental health status, consistent with many analogous urban health studies. MacIntyre and colleagues (1993) explained how environmental conditions and the availability of inexpensive healthy foods, quality of health services, differences in crime rates and a less hostile environment affect mortality rates. In another region, studies of social conflict and criminal violence have also demonstrated their impact on health and well-being in four Latin American countries (Moser, 1996). Simply put, the places where people live have a sizeable impact on

overall health and well-being, and it is important to know which factors are particularly significant in that regard. Our study demonstrates that people identify similar links between localized afflictions and common mental health problems.

Consideration of gender helps to explain the effects of various social stressors on mental health, and our findings show how particular features of gender and culture affect mental health in the Malavani community. These findings complement many other studies showing high rates of common mental disorders, especially depression, for women (Pearlin & Johnson, 1977; Makosky, 1982; Belle, 1990; Dennerstein et al., 1993). Research is notable for sex differences, with higher rates of these disorders affecting women in India and worldwide (Brown & Harris, 1978; Ponnudurai & Jaykar, 1980; Gilmartin, 1990; Koss, 1990; Stark & Flitcraft, 1991; Leidig, 1992; Davar, 1995; Broadhead & Abas, 1998). Our ethnographic findings indicate the substantial role of gender differences in education, employment opportunities, household and community entitlements, and particular forms of victimization. Although such conditions render both men and women vulnerable, it is often in different ways. The mental health problems that result are typically experienced and communicated as various gender-and stressor-specific forms of tension.

Approaches to mental health policy and planning for community mental health benefit from attention to priorities defined with reference to local sociocultural contexts. A focus on the context of these 'tensions' is required to promote mental health with reference to local stressors and supports, and to complement curative mental health services for psychiatric disorders (WHO, 1984). Community development that aims to foster mental health should acknowledge gender-specific needs of women and men, and endeavor to provide more opportunities; ensure

adequate infrastructure; and prevent exploitation, victimization and domestic violence.

As a mental health study, our approach is somewhat unusual, insofar as it is concerned with non-specific mental health issues (e.g. emotional distress, subjective quality of life of poor people living in deprived conditions) and the role of poor hygiene and sanitation, population density, hutment demolition, homelessness, violence and crime—rather than rates and determinants of psychiatric disorders per se. Our concern with population mental health, however, requires such an approach to address the interests of illness prevention and health promotion, just as psychiatric epidemiological studies are required to address the interests of curative medicine and psychiatry (WHO, 2002). Our findings and our approach also show how paradigms for population health may be extended to mental health (Friedman & Starfield, 2003; Kindig & Stoddart, 2003).

Just as psychiatric epidemiology is required to specify the burden of mental disorders; complementary approaches to mental health research are needed to address interdisciplinary academic interests and practical needs for mental health planning. Ethnographic studies like this one explain afflictions and their influence on emotional experience and mental health in particular contexts. Cultural epidemiology explains how mental health problems are configured with reference to local categories and narratives of experience, meaning and behaviour (Weiss, 1997, 2001). The formulation and development of informed global, national, and local priorities for mental health require guidance from a complementary mix of these research orientations (Weiss et al., 2001).

New public health initiatives of the 19th century brought about substantial decline in deaths from infectious diseases through sanitary reform, and we now need

to consider how analogous population-based measures may be adapted to promote mental health. Consider, for example, the paradigm of infectious diarrhoeal diseases; without attention to hygiene and sanitation, antibiotics can make only a limited contribution to improving population health. Similarly, although antidepressants have an important role to play in treating patients with clinical depression, they cannot directly improve difficult living conditions or tame hostile social environments that produce depression and impair mental health in other ways. Findings from this study are currently guiding a community mental health programme for Malavani, and we hope that the example of this research may also be useful in formulating local strategies for other programmes as well.

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Chapter 3

Ethnography of common mental health problems in an urban slum community

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GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

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Ethnography of common mental health problems in an urban slum

Abstract

Notwithstanding the value of psychiatric epidemiology to guide mental health policy, additional complementary methods are also required to meet some of the most challenging needs in the most deprived settings. Community diagnostic profiles provide only part of the story, and it is not just the classification and information about the distribution of mental disorders, but a broader appreciation of the context and content of mental health problems that is required. Furthermore, inasmuch as most psychiatric diagnostic criteria are formulated with reference to clinical experience, they have limitations for application in community studies, and such limitations are even greater in distinctive settings apart from Euro-American clinics and cultures. The research reported in this chapter examined the nature of mental health problems in an urban slum of an Indian megacity, the Malavani slum community in Mumbai. Employing ethnographic methods, it studied the various local formulations of emotional distress and mental health problems with respect to associated experience, meaning and behaviour, and with reference to gender and socio-cultural contexts. Findings indicate the impact of such disadvantaged settings in defining the nature of problems and their relevance to identify approaches for appropriate responses in an effective community-based mental health system. This research shows how an appreciation of ethnic and cultural diversities should be taken into account. Findings elaborate the stressors imposed by unemployment, substance dependence, and the pattern of general dependence among men that develops in this setting, which lacks adequate infrastructure and opportunities. Women are routinely compelled to accept patterns of abuse that challenge their

endurance, ability to cope, and resilience. We consider how this ethnographic account informs our appreciation of the local meaning and concepts of distress, disorder, and mental health. Subsequent chapters indicate how this ethnography complements cultural and psychiatric epidemiology, demonstrating the value of an integrated approach to research to address the most pressing urban mental health needs.

Introduction

In the field of psychiatric epidemiology, the past several decades have been marked by notable progress in the number of studies, their scope, methodological developments, and interdisciplinary collaborations with neurology, neurobiology, sociology, and anthropology. Such research is required to enhance understanding of mental illness for clinical and public health, guiding international agencies developing effective interventions. These studies have also been limited by several shortcomings. They have not covered the complete range of diagnoses; they have not adequately incorporated threshold criteria for clinical significance and discrimination between disorders; they have not incorporated assessments of disability, impairment, and health service utilisation or formulated adequate assessments of needs; and finally, they do not adequately account for cross-national and cross-cultural variations (Wittchen, 2000). The Harvard University *World Mental Health Report* (Desjarlais et al, 1995) highlights needs for a new generation of culturally informed epidemiological studies that more precisely signify local representation of mental health problems. Fulfilling that goal for epidemiological research would provide a needed guide for national and global mental health programmes and validate local models of community mental health.

Two decades ago, Sartorius and Harding (1983) argued that primary health care changes attitudes towards disease and health in general and especially towards mental illness as health policies become more sensitive to the psychosocial features of local context. Mental health professionals in low and middle-income countries have also considered the alternatives to hospitals and regarded the primary health care approaches to mental health care as advantageous and appropriate. The guiding principle is the context of rethinking the knowledge base required to inform

an efficient community mental health system. Current systems of psychiatric diagnosis are, for the most part, based on clinical characteristics of patients seen in psychiatric specialty practice, and criteria based on this experience are typically used to assess mental health problems in the general population. This approach, however, disregards differences in applying these criteria in the community and among clinic patients reaching psychiatric attention, that is, patients who have pursued a course of professional help seeking.

Clinical assessment is a complex matter, and the question of what constitutes an appropriate framework for assessment of mental health problems in the community is still more complex. Various versions of WHO's *The International Classification of Diseases (ICD)* and the American Psychiatric Association's *Diagnostic Statistical Manual of Mental Disorders (DSM)* have enhanced interrater diagnostic agreement among researchers and clinicians, thereby improving statistical reporting of psychiatric morbidity; accounts of mental health service use, treatments, and outcomes, and promoting consistency in teaching psychopathology. Difficulties addressing more difficult questions of validity, however, obscure features of complex relationships between community priorities for local programmes and professional priorities for community interventions mental health services, and approaches to defining, preventing and treating community mental health problems, and to promoting mental health. Culturally distinctive clinical states too often remain undiagnosed, or they are relegated to residual categories, typically termed "not otherwise specified (NOS)," which lack clinical salience and provide an ambiguous guide to treatment.

Explicit diagnostic criteria and rule-based classification may ignore local mental health priorities in clinical practice if phenomenology, inter-subjectivity and

the inherent historicism of key concepts about mental illness are ignored (Jablensky, 1999). Even though it may guide some aspects of treatment, diagnostic information itself does not necessarily explain what is disabling about a mental health problem, ways of responding to the broader impact of illness beyond symptomatology, or the particular needs of patients. In addition to symptomatic relief, patients may also desire their doctors to interpret personal suffering, give it meaning, and thereby provide relief. Studies conducted by the Royal College of Psychiatry in the UK in their campaigns to “defeat depression” and to change stigmatising public perceptions of mental illness have examined public attitudes and misperceptions about mental illness and related treatments (Priest, 1996; Crisp, 1999). Other studies have long been concerned with the role of cultural beliefs that shape societal responses to people with mental illness (Hollingshed and Redlick, 1958; Nunnally, 1981). Cultural concepts of mental illness also affect help-seeking behaviours, stereotyping and stigmatisation of mental illnesses. Recognising such practical implications, this chapter examines popular beliefs and cultural perceptions of mental health problems in an urban slum community of Mumbai.

Aims and objectives

This study aimed to clarify local perceptions and the context of mental health problems in Mumbai’s Malavani slum community, representing the vantage point of the people with such mental health problems. Ethnographic interests focussed on mental health problem-related experience, meaning and behaviour with reference to gender and social context. The study aimed to identify key aspects of mental health problems for subsequent clinic-based cultural epidemiological study of patients, and to provide an awareness of local priorities concerning mental illness to guide a

community-based mental health programme. It was particularly concerned with elaborating local sociocultural concepts of mental health problems with a particular focus on the role of gender.

Methods

An ethnographic community-based study made use of multiple methods and a focused agenda, based on the approach developed in Sunderban Delta in rural West Bengal (Chowdhury et al, 2001), for our research in urban slum community. Open-ended and semi-structured interviews were administered to identify concepts of mental health problems and approaches to help seeking. Observations and participation in the day-to-day life of the Malavani community were planned in the course of establishing clinical services and psycho-education for the community. Useful information about the social context of mental illness and emotional problems came from informal meetings and discussions with community residents and relatives of our patients. Additional information came from clinicians, nurses, social workers, and other clinic staff of the Malavani primary health centre (PHC).

In all, 78 adult participants of various age range including 43 women and 44 men participated in study. They were interviewed in three separate focus groups, including one group of 11 women, one group of 13 men and one mixed-sex group consisting of 15 community members (8 men and 7 women). The remaining community participants (18 women and 13 men), participated in in-depth interview. In addition, the first 8 patients with appointments at the primary health centre (4 men and 4 women), participated in the in-depth interview.

Focus groups were conducted with community residents, addressing points of the ethnographic research agenda (Textbox 3. 1). Despite a systematic agenda, an

informal style of interactions helped to make participants comfortable in speaking with research staff. The association of the research with clinical and community services and the role of community facilitators taking part in the study helped to gain access to and trust of the community, and facilitated friendly interactions with reference to points of the agenda.

In-depth individual interviews were conducted with the cooperation and voluntary participation of community residents and with several outpatients of the PHC. Focus group meetings were conducted either in the PHC clinics or in homes of community residents, considering their convenience to promote participation of female participants. Focus groups examined subjective experience and a range of local opinions, attitudes, and beliefs related to specific themes and local concepts through group process (Kitzinger, 1995).

Interviews typically began with a general discussion about the community, its problems, and facilities to establish a rapport and broad scope of research interests. Subsequently these interviews focussed on the concepts and understanding of mental health problems. Spontaneous interactions were encouraged with free flowing conversation, but with explicit follow-up questions to clarify issues of particular concern to the agenda, as required. Local concepts of mental health were discussed according to local concepts without reference to specific psychiatric diagnoses. Interviewers and focus group leaders subsequently addressed particular mental health topics, such as alcohol and drugs, suicide and deliberate self-harm (DSH), and possession syndromes.

Two research assistants recorded data in the focus group discussions. Social workers and psychiatrists on the research team conducted focus group interviews. Research assistants conducted and documented individual in-depth interviews.

Results and findings were managed and analysed initially with Winmax programme, and subsequently updated to MAXqda. The structure of this agenda provided a framework for coding, which was augmented with free-form coding. Each theme was examined in detail to understand common views and perceptions of people, especially as they informed the nature of mental health problems, ideas about their causes, help seeking, and other community ideas about them. Aspects of the gendered context were examined as a crosscutting interest. Guidelines of the research agenda were used to guide analysis of the data set.

Textbox 3.1: Agenda for community ethnographic study of mental health problems

- Distinguish various types of emotional distress associated either with life problems, medical problems, and mental health problems, or a combination of these
- Identify local concepts of common and serious mental health problems
- Identify characteristic social contexts of mental health problems
- Distinguish concepts of natural and supernatural disorders related to mental health
- Identify other perceived causes of mental health problems
- Identify patterns and settings of problem alcohol and substance use
- Identify attitudes and ways of understanding suicide and suicidal behaviour
- Identify supportive and stigmatizing social responses to mental health problems
- Identify local preferences and practices of help seeking for mental health problems

Results

There are lay terms and words indicating a range of everyday emotional problems and more serious mental health problems (Table 3.1). This section presents these concepts and vocabulary related to common mental health problems, serious mental disorders related experience, meaning and behaviour with reference to gender and the social context. In addition, we also present other mental health related behaviour such as problems of alcohol and substance abuse and suicidal behaviour, which we found to be relevant in this study.

Table 3.1: Concepts and vocabulary of mental health problems

Concepts and items	**Comments**
Tension Also known as *chinta ,fikiir tanav, taan, pareshani, kaljii, taap ,etc* • Everyday tension(*Roj ka tensioni)* • Tension Illness(*Tension ki Bimari*)	General feelings of distress, strain, and apprehension related to social and interpersonal problems • Emotional problems in the course of a stressful daily life (e.g. bad water, access to toilets, poor infrastructure, feared demolition of dwelling, quarrels, etc). • Similar but more intense and disabling features of everyday tension
Serious mental illness Local terms include *veda, pagalpan, mad, crackpot, pisa, veda-pisa, chakram, khulachat, khula, Diwana etc* • Natural conditions (Kudarati) • Supernatural (Gairkudarati, Daivi, Jadu, Muth)	Bizarre and dangerous behaviour. Quarrelsome and abusive interactions, wandering, dirty with neglect of hygiene • Conditions associated with the body and amenable to medical interventions. • Conditions reflecting spirit possession and black magic.

Common mental health problem (CMHP)-tension

Participants used various terms for the day-to-day emotional problems and serious mental health problems that concerned their life in the community. They used a variety of words in their slang communication such as, *chinta, fikir tanav, tan, pareshani, kalji, tap,* etc. In essence, these words indicated stress and related worry of different intensities. Among these, tension was the most popularly acknowledged word to describe a range of emotional problems in the urban community. The concept appeared to be built in to people's vocabulary and life stories. They recognize it as a modern word, reasonably explaining the problems that are related to city life, more in terms of day-to-day struggles in their environment. One woman in a focus group explained that the word tension is wide-ranging and can express personal problems and associated sufferings. In focus group discussions, tension was identified as a common problem affecting around, 75-80% of the population and cutting across all the ages and sexes.

Tension was associated with numerous symptoms, mainly, of the body and emotional. The common bodily symptoms identified were giddiness or *chakkar,* headache, general weakness, palpitation (*dhadkan*), chest pain, and pain in abdomen, loss of appetite and lack of sleep, lethargy, etc. Tension-related emotional disturbances reported were irritability (*chidchid),* sadness (*gum*, *dukhi,* and *udhas*), anger (*santap* and *ghussa)* and worry (*cinta*)*.* Other, less commonly reported symptoms, were quietness *(gumsum)* and tiredness (*thakan*). Women considered tensions related to marriage and having an alcoholic husband serious by women, and men perceived joblessness and financial difficulties as serious. Several typical features of tension are described by residents below, indicating the diversity of its

sources, the particular impact of family, and ways of experiencing and relieving tension:

> Tension may be due a variety of reasons such as job, house, and children. I am tensed because my husband does not earn. When I am tensed, I hit my children. I feel very angry, my head becomes hot (*tap*). I don't know what to do, specifically to decrease my tension. I do not know anything about treatment for tension. *Chinta*, *fikir*, tension- all means the same things. I do not think there is any medicine for tension we just have to make people understand that they should not take any tension.

> I have heard about tension. One can be tensed due to family problems (*gharachi fikir*). Because of tension, one can have a headache or a fit or even a heart attack and giddiness. Everybody has tension. If there is a headache or pain then one can take treatment from the doctor. There is no treatment just for tension. When I get tension, I just sit quietly.

> In tension, people sit quietly, may take cigarettes (*bidi*) to decrease tension. They don't feel like talking to anyone. They do not sleep properly. They do not go to doctor for tension. I do not know if there is treatment for tension. Tension could be due to money matters, family matters, children, extra marital affairs. In tension, people have headaches, giddiness. They worry a lot. Ninety percent of people in Malavani have tension.

Everyday tension (rojka tension)

Most of the emotional distress or tension (*rojka tension*) arises from the daily hassles of life in the community. However, everyday tensions are not necessarily disabling, even though they are responsible for feelings of generalised dissatisfaction and interfere with one's ability to enjoy life. The following two narratives explain this aspect. A 35 year-old male participant said in his in-depth interview,

> These everyday tension and problems make you feel worried (*pareshan*) and they swallow the vital juices of life (*jindgi ka ras pi jate hai*), but then you have to carry on because life does not wait.

A young woman participant from a focus group who worked very hard because her husband was not earning said,

> It seems that I work 48 hours in a day. Life has become a burden with all sorts of tension, but it is going on right now. The boatman is tired, but he sails on okay *(mazi thak gaya hai lekin Naiyya thik chal rahi hai*).

Tension illness (tension ki bimari)

When tension was identified as illness, or *tension ki Bimari,* it was considered both severe and disabling. It limited one's capacity to perform day-to-day activities or fulfil occupational commitments. Men reported that they slept at odd hours and did not go to work, neglected their duties and sometimes drank alcohol in response to their tension illness while dependant family members suffered. Women found it difficult to engage in their routine household responsibilities. They felt as if they were dragged through the day (*din khinch raha hai*). Occasionally, children were kept waiting for food which mothers suffering from tension had not prepared. They shouted at children unnecessarily and some mothers did not send their children to

school. One woman who was undergoing treatment for major depression in the clinic narrated the entire progress of how simple every day tension had grown to be a severe tension illness,

> When tension was less, I was a bit nervous, a bit irritable. I used to think a lot about my husband's unemployment all the time but, I managed my work, looked after children, cooked properly though sometimes shouted at children or fought with husband. However, lately I am unable to manage this tension I have become ill with it (*Tension ki bimari*). I have become a sort of reckless (*Ape ke bahar Jati Hun*). I do not cook properly. I shout at my children frequently. I feel I am not able to take it anymore. Nobody is helping me now. My brothers stopped helping me. I do not know what to do, how to run this house, how to feed my children. No peace of mind, I feel I am becoming fiery now (*Manko shanti nahi hai, Jaise aag ban gayi hun*).

Tension problems were explained to be caused by sad life stories (*Dukhbhari kahani)* in general. While the specific problems like financial and unemployment, lack of opportunities and demoralization were more associated to men, harassment by in laws, alcoholism and extramarital affairs of husbands, wife-beating and domestic violence was distinctive for women. Gender stereotypes were suggestive because there was a general understanding regarding the "weak personality of women" and the lack of support for widespread tension in women in Malavani.

For tension illness (*tension ki bimari*), people considered everything right from doctor to faith healer as helpful, depending upon symptoms. For routine tensions, (*roj ka tension*) finding out solutions to the problems was considered. According to the respondents, for somatic symptoms like body ache, headache, tiredness, sleep

disturbances, doctors can help with medicine. For other symptoms, like emotional problems such as irritability, anger, and sadness, can only be helped by social interventions like receiving help from one's relatives, care and empathy from people and sometimes, faith healing. Faith healing included visiting faith healers and temples, practising religious rituals like fasts and vows, and making offerings to famous deities. For example, one woman, who was suffering from tension illness because of infertility said that she sought help from a woman believed to be possessed by goddess. After complying with rituals suggested by possessed woman, she conceived and was relieved of her tension.

In focus group discussions, participants suggested that helping and supporting each other, visiting native places, reading self-help books, listening to music, practicing yoga, and religious involvement can help people relieve tensions. Overall, participants reported that improvement of the general living conditions and provision of basic opportunities like housing and employment would reduce their sufferings and associated tensions. One man in a focus group shared the general feelings of the community,

> If the government would take account of our needs and try to improve our dilapidated state of living, and consider us human beings, maybe then we will benefit. Our daily troubles are because we are not provided with basic things. Nobody bothers about our lives. If the government helps us, we will be obliged, and then our tensions would reduce a lot.

Severe mental disorders

Most common terms and concepts of serious mental illness described features such as self-neglect, wandering on the roads, dangerousness to people,

unpredictability, talking to themselves, using bad words and abusive interpersonal interactions. Further, these people were described as bizarre and characterized by weird behaviour (*vichitra* or *vikshipta*). Their unpredictable behaviour was frightening to others as indicated in the following narrative account,

> They are bizarre (*vichitra*), far away from normal people and you cannot expect anything simple and straight from them. God only knows how they think and what they think. You never know what they will do next moment. They may attack you without reason. People have to be very careful from them.

Many participants were familiar with the various terms for mental illness in their informal discourse. However, the term mental illness as they elaborated indicated the serious condition that had more often-negative behaviour attributions. They identified it as *Mansik ajar* or *Mansik bimari,* which, in local terms, are tangible translations of concepts of mental illnesses. The common idioms such as *veda, pagal/pagalpan,* mad, crackpot*, pisa, veda-pisa, chakram, khulachat, khula* correspond to extreme forms of socially unacceptable behavioural disturbances. Many of these images of mental illness were derived from both experience with such people in their community, as well as from media sources including popular cinema and newspapers. A specific account was remembered by many about a mad man called as *patthar-mar* (one who killed people with stones) who was discussed in newspapers for trying to kill people in the Mumbai.

Most respondents have also seen homeless mentally ill wandering on roads. Few in focus group denied knowledge of mental illness, nevertheless described some good examples of affected person. Common descriptions of these terms are indicated by the following examples:

> Mad people throw mud on people, roam around naked on the streets, eat anything, mosquitoes fly in and out of their mouth.

> There are mad people (*chakrams*) who laugh without reason talk irrelevantly, are irritable, hit other people without reason, and remain dirty.

> I have not heard of mental illness (*Mansik azar*). I have seen mad people on the roads; they throw stones, don't think about consequences of their actions, and they talk to themselves. They stare into space, go in the gutter and pass stools in their clothes. Mad people are those who run away from home, do nutty things, and wear dirty clothes.

Although such features characterised the popular prototype of mental illness, it was not clear that these conditions were health problems that benefit from medical treatment. Some forms of mental problems were attributed to some social and age related factors. The man or woman who become mentally ill due to rejection in a love affair is labelled as *Diwana* (man) and *Diwanee* (woman) or *Bawra* or *Bawree*, and they received sympathy from people. The other terms indicated deficient intellectual capacity and lack of wisdom than mental illness (*akkalshunya, be-akkal, budhibhranstha, murkh,* brainless, etc.*).* Terms like screw *dhila* (loosening of screw) or *atta dhila (*loose screw*)* or *satak gayan* (out of place) were used less often by younger generations, referring to some kind of technical or mechanical problem as a metaphor for impaired function of brain. Some other common words were more age related such as, *Sathia gayan* or *Mhatar-chal* (by age of sixty people start loosing

wisdom and show abnormal behaviour) and *Gadhe-panchvishi* (donkey like behaviour by age of twenty-five). The words such as *Jahil* (primitive animal like behaviour), *Anari* (ignorant and insensible person) or *Ganwar* (Gaucherie*)* indicated humiliation and disrespect.

Natural and supernatural mental disturbances and illness

Further categorisation of serious mental disorders by people as natural (*Kudarati*) or within the human body and supernatural (*Gair kudarati*) were often a result of their cultural beliefs related to black magic, devil or evil spirit, and possession.

Many respondents described possession as a religious or supernatural phenomenon in which some deity or soul or spirit enters in the human body. Possession was recognised as commonly affecting women. However, most male participants doubted its authenticity, arguing that it is only quackery, and that it cheats ignorant and troubled people. Some examples discussed in focus groups explained this phenomenon in detail. Deities enter in the body of some distinctive people to bless them, to ward of effect of evil eye (*najar lagana*) and to provide solutions (*upchar*) to their problems. Goddesses generally possess women. One woman narrated the story of her daughter who suddenly became frenzied at the time of examination. First, she was taken to the local doctor who treated her, but there was no improvement. Based on neighbour's suggestion, this woman was taken to a woman known as *Tuljamata* (woman who is possessed by a goddess from Maharasthra). *Tuljamata* explained that the young girl is scholarly but someone jealous has cause her problems with black magic (called as *muth*), so as to damage her performance in examination. She gave them sacred powder (*angara)* and asked

the mother to keep a fast and a vow (*vrata*) on one day each week. She also advised the girl's mother to visit a deity (*Tulajamata*) and to make the offerings of coconut, raw rice, and fruits. After these duties were fulfilled, the woman claimed that her daughter was all right.

As a second type of supernatural illness, people believed that bad spirits exist in the world (after the dissatisfied and mysterious death of some people) and they take revenge on other innocent people. Participants explained that these spirits catch people alone in the night in toilets, or in empty places, scare them, and then posses them. One female respondent elaborated this in the following story. The woman's pregnant daughter visited her sister-in-law's home, and there she was possessed by the soul of her sister-in-law's, daughter-in-law who died in pregnancy due to jaundice. After that, her pregnant daughter frequently fell into trances (*behosh)*. Relatives identified the phenomenon as possession and took her to a faith healer in Malavani. The faith healer explained that the dissatisfied soul of the pregnant woman had possessed her and the soul of the pregnant woman needed to be contented. As per the faith healers advice, the family of the possessed woman offered good food and clothes to a married pregnant woman, which symbolically represented the spirit of the dead pregnant woman from the community. The possessed woman's condition improved following the rituals.

A few people who had personal experience with mental illness regarded serious mental disorders as a medical problem. These people attributed the problem to serious brain damage, nerve damage (*nas* ki bimari), infection with fever (*dimag me tap chad gaya*), or even epilepsy(*fefra* or *Mirgi*). A very common cause identified by respondents was the relationship of mental illness with a day with a full moon (*Purnima)* and a day with no moon (*Amvasya),* which were times when such

problems were aggravated. Serious mental disorders due to supernatural causes were considered responsive not only to medical interventions, but faith-healing was also thought to be effective remedy. On interview a Muslim faith healer who established his practice for dealing with similar problems, explained,

> When the illness is because of supernatural (*gairkudarti*) causes, then it is outside the range of human power, in that case faith healers with compatible powers are required to control these supernatural forces. That is not ordinary human job to deal with such issues. The faith healers go through tough and dedicated religious preparation to acquire such an extraordinary power. You have to drive those supernatural entities away as soon as possible and never should allow them to settle in possessed body; otherwise it is difficult even for us to control them. They required to be immobilized forever by annihilating their power. Medicine will not work independently; a lot of divine blessing will be required.

Many people were aware of mental hospitals, psychiatrists (*pagalon ka* doctor) and the use of tablets, special injections, and electroconvulsive treatment in serious mental disorders. One elderly male participant informed us that his daughter got well with electro-convulsive treatment (commonly known as shock treatment), and he explained that as she developed mental illness due to sudden shock (*sadma*), the electro-convulsive treatment helped her by nullifying her emotional shock. However, distrustful stories depicted in popular media and informal gossips, like using biological treatments with devious motives, such as medicines to keep

people purposely out of sense, or giving electro-convulsive therapy to weaken memory of individuals, had a negative impact on people's impressions of medical treatments. Being an urban environment, the majority of participants did not deny the importance of modern medicine absolutely. One elderly woman clarified that previously, she believed only in faith-healing but now in the city she learnt about all sorts of complicated illnesses that were cured with modern medicine. She detailed,

> Science has improved so much in the city. The big doctors are available so one should take advantage of both. Both faith healing and modern medicine together will be more effective than each individually. In village you will not get both, as doctors are not sophisticated like in city so faith-healing is perhaps better choice there, but in city it should be both as it is available.

People suffering from serious mental disorders with peculiar abnormal behaviour are looked down upon with disrespect and un-supportive attitudes. Participants felt people are scared of their intimidating behaviour and kept away from such people. In one of the focus group, residents elaborated this with an example where community residents beat a horrid looking mad man to death because they feared that he might harm a young girl who he had tried to touch. In another example, fearful residents took such a mad man to police because he was walking naked on the road.

Some accounts reflected an element of stigma and shame. We knew of a patient brought to us by his father after a psycho-educational group meeting in the community. This was a man of 36 years-old and suffering from abnormal behaviour,

self-neglect, withdrawn, vacant stares and had been muttering to self for the last 10-12 years. Besides faith-healing practices, he was never taken to any recognised health care providers. His father expressed his apprehension that his son and his family would be thrown out of the community. In addition, there could have been difficulty for his two daughters' marriage if people knew about his son's problems. The most important focus remained the theme of marriage, where mentally ill people were expected to face difficulty in getting married as elaborated in following narratives.

> People don't give them respect (*sanman*). They can't get married. Mental illness is not considered good, as these mad people will never improve.

> Society does not behave properly with mad people and in fact victimizes them sometimes. If people know you are mentally ill, you will never get married that is the reason why people don't talk about this. That's why relatives of mentally ill are forced to cheat other party.

Suicide and suicidal behaviour

In focus group discussions, participants' responses regarding DSH and suicide were generally sparse. However, in individual interview sessions, people spoke more overtly. General statements indicated that respondents commonly had heard about suicide in Malavani, and that it is more frequent among married women and younger people. Most participants did not consider suicide to be a result of mental illness, but rather, they felt that it was mainly due to emotional and

interpersonal problems, and difficult social situations. Many women attributed suicide to a husband's irresponsible behaviour, particularly infidelity and brutal beating, alcoholism, abuse and harassment by in-laws. A woman who worked with our health staff had a daughter who burnt herself because of her husband's cruelty, elaborated,

> A woman is like a poor cow (*garib gai*) who is taken to husbands home to be tied down, then he tortures her mercilessly like butcher (*khatik*). She bleeds every day no matter what. What else she can do, as an alternatives to dying every day, it better she finishes it forever (*roj roj marnese acha hai ek bar hi mare*). At least she escapes this torture forever.

Other women in focus groups explained feelings of being trapped in particular situations that can lead to DSH. One woman reported,

> If they are going to burn you sometime, it is better to burn and free yourself from all the agony at once.

Many individual interviews had similar accounts of suicide as a way of dealing with anguish for women, especially young women, after family fights and interpersonal problems. People reported that they had heard of recent events of suicide attempts by youths after exam failure, and unemployment problems. Respondents who had children themselves expressed concern in focus groups about the recent trends of young girls attempting suicide following a broken love affair. They found it very difficult to handle this problem socially and interpersonally, and indicated that they were burdened by the uncertain future of these "spoiled" (*badnam*) girls with respect to their marriagability. A woman who faced such a problem with her young daughter elaborated:

> Nowadays getting into a love affair has become a fashion for young generation. City life has freed them of inhibitions. They think they are modern city girls. They see movies where a young girl is in love and runs away with boys. Under all this influence, these girls act so immaturely. But then nothing happens to the boys when these complications take place. And our young daughters don't know what to do. The boy refuses to marry after he enjoys her and the girls consume poison. Nobody blames these boys. These girls just add trouble into rest of our sufferings. We can't even control them nowadays with so much of prevailing atmosphere. For them, a love affair is children's game and life has become cheap. This is a new headache for parents of young girls nowadays.

In general, suicide was understood as an unfortunate response to a miserable living (*zindagi se tang*), or to a severe tension beyond one's capacity (*bardasht ke bahar*). Many respondents considered it as outcome of intense suffering, entrapment in circumstances, and people's inability to find solution.

Some men attributed female suicides to the constitutional weakness of women that leads to their poor coping styles and suicidal manipulation. As suicide and DSH was considered a serious emotional crisis related to the social context and interpersonal relationships, social interventions and problem solving approaches were considered as useful. Most of the women felt that care and support at home would prevent many women from committing suicide. It was also felt that better opportunities in terms of employment and education would also reduce the number of suicides in men. Although people were aware of it, suicide and DSH were evaded topics in the community. Suicides by young girls were condemned as an outcome of

immature and immoral behaviour like love affairs or illicit relationships, while suicides by married women were looked at more sympathetically by virtue of their enormous sufferings.

Alcohol and substance use

Many people in the community regard addictive problems especially alcohol as a major problem, mainly among men. It is the root cause of many other social problems like criminality and violence in the community. Very few participants justified drinking alcohol as a tension-relieving solution for hard-working men in a stressful community. Women did not object their husbands' addictions when it did not affect their family life. However, according to community residents (from focus groups and in-depth interviews), alcoholism affects 60-70% of the population. The atmosphere in Malavani was perceived as encouraging to drug addiction. Residents however did not think that alcohol and drug abuse was a mental health problem, but they did recognize it as a social problem. Respondents felt that addictions began with simple habits due to peer influence or as a result of social tensions; in both situations, it was perceived that there is someone in the community who influences those susceptible. Men's vulnerable personalities, their frustrations and despair related to their subjugation in life, as well as their antisocial characteristics were all regarded as potential causes of men's addictions. This was emphasised explicitly by one elderly resident who had alcoholic son,

> Sometimes by habit, (*Shaukse*) and sometimes to reduce tension, they start drinking. It is easy to get hooked in these habits. In Malavani, people are waiting to corrupt you as they want to earn money by selling these drugs and alcohol. These boys like my son first enjoy the

> excitement (*Badi mastime rahte hai*) and then go beyond the control (*ape ke bahar jate hai*). They spoil society, bring on violence and loosen the moral fabric of society. After sometime, they no longer can behave like humans, they become like animals (*insanse janvar bante hai*). I do not think it is mental illness. These people need will power and moral strength to get out of it. Sometimes a *Fakir* (Muslim faith healer) can control them. I took my son to Ajmer in Northen India where *Fakir baba* helped him out with some religious rituals.

Besides associating social causes to alcohol and drug problems, some women who participated in the community drug awareness program recognised drugs and alcohol as a kind of medical problem that doctors may be able to help with. Many respondents had heard about women's addiction and drinking alcohol but this issue remained silent in discussions.

Medical interventions for the physical complications such as liver problems associated with drug addiction and alcoholism were considered beneficial. However, spiritual and religious interventions were considered useful for giving up these bad habits. People reported that a Buddhist group in the community was practising this process and that people found it useful. People also considered that building social pressures and imposing shame on alcoholics for their irresponsible drinking behaviours were useful. There was a general expression anger and antipathy toward alcoholics and addicts and their problems were regarded as social nuisances that were created by irresponsible and antisocial behaviour.

Discussion

The cultural epidemiological approach employed in this research provided a wide spectrum of personal experiences as well as community views regarding various mental health problems, which are difficult to attain using classical epidemiological approaches. The various methodological approaches used in the study helped to explore both broader and more discrete features of mental health issues in a heterogeneous, multiethnic, and multilingual urban slum. The attention to gendered context identified the nature and experience of mental health problems and their associated stresses in the slum community.

Common mental health problems

The concept of tension has provided people a common and acceptable language to express their stresses and related emotional problems. The dimensional view of tension as tolerable, routine, emotional distress without serious disability seems to be a shared and accepted appraisal of emotional distress in the community. Respondents indicated that tension had both emotional and somatic dimensions, which not only express personal sufferings, but also convey professional concepts of common mental disorders such as depression and anxiety. Goldberg and Huxley (1992) explained that milder mental disorders fit a dimensional model as well as they fit a categorical one. Our study brings forth two issues; first, that the local expressions of CMHP are diverse, and second, that the international diagnostic system is limited in measuring the diverse nature of these problems.

The urban context of the slum community on the experience, meaning, and behaviour of mental health problems is significant. It shapes attitudes toward modern medicine toward the experience of mental suffering. Community members appear to

simultaneously be adaptive to the stresses of slum life and vulnerable to it, made clear in the widespread occurrence and acceptance of the term, ‘tensions’.

Serious mental illnesses

The respondents’ understanding of serious mental illnesses was somewhat generic. They frequently associated severe behavioural abnormalities, dangerousness, and unpredictability with severe mental illnesses. In many other studies, these features are acknowledged as stereotypes of mental illnesses (Nunnally J, 1981; Link B et al, 1987; Angermeyer M, 1996; Pen D et al, 1994; Link B et al., 1999). Further identification of serious mental disorders as natural (*kudarati*) and supernatural (*Gair kudarati*) were ideas guided by beliefs held by faith healers. Supernatural causes have been recognised as important causes of mental disorders in non-western societies (Razali et al, 1996). Respondents reported somatic origins of mental illness such as head injury, or damage to the brain, fever, and epilepsy.

Respondents’ somatic conceptualizations of mental health problems had direct implications in understanding of why people with common mental health problems sought medical help in primary or general health care. Tension-related symptoms, especially bodily complaints and sleep disturbances, were considered suitable criteria for medical intervention in study from India (Raguram et al, 2001). Nevertheless, faith healing was considered as an invaluable intervention for serious mental disorders and was recommended as complimentary to medical intervention. The urban influence of the slum community seemed to be instrumental in people accepting modern medical interventions alongside faith healing.

Community members often labelled alcoholism, addictions, and suicidal behaviours as interpersonal and social problems. The association of religion,

morality and values with alcoholism, addictions and suicidal behaviour presents a challenge to the current medical models of prevention programmes. Associated help seeking for these problems appears to be more complex and is guided by local perceptions, and therefore, community participation is essential in the planning of successful suicide and addiction prevention programmes.

Gender context

Gender-specific issues related to common mental health problems were identified in respondents' expressions of emotional distress, the associated causes and social response to their emotional distress. Social distress is a much more important feature of distress in terms of understanding the gendered context, specifically in recognizing the social origins of psychological distress among women (Makosky, 1982; Dennerstein et al, 1993; Pearlin et al, 1977; Belle D, 1990). Similarly, the predominance of alcohol and substance use in men was a major concern of the community and particularly for women who face additional social problems when their husbands and fathers have such addictions.

Implications for community mental health programmes

Larger community surveys with tightly structured instruments provide very useful sophisticated data on the magnitude of the problem but lack information on people's perceptions and explanations of mental health problems, which are relevant to clinical and public health practices. This study has already led to the incorporation of the local language of common mental health problems to develop psycho-educational programmes that are community sensitive and based on peoples expectations of mental health programmes. It also contributed to the development of

clinical communication skills in psychiatric training and education for multidisciplinary trainees. It provided a basic framework of knowledge for the local adaptation of an instrument EMIC, to study the gender-specific clinical cultural epidemiology of CMHP in Malavani, discussed in chapter 4. This research is an example of an evolving local community programme and research agenda, and is not only helpful in the development of locally effective intervention strategies, but can also guide national and global mental health policies (Weiss, 2001).

Respondents indicated that the most realistic support to reduce daily tensions would be for the government or voluntary organizations to improve the slum's living conditions. Community members felt that tension-related problems were normal emotional distress that could be handled through self-help and social support. Goldberg and Huxley (1992) reported evidence for the efficacy of social support in mild depressive status. For men, employment opportunities were considered as the best form of help, while for women, an employed, non-alcoholic husband, who does not abuse them, would help prevent tension.

Conclusion

Having identified the burden of mental health problems in the Malvani slum community, we must also identify appropriate recourse. Unless and until we understand the indigenous language used to express mental health in this context, planning and implementation of effective mental health programmes at various levels will be difficult. Ethnographic studies should be a part of epidemiological research for mental health and community mental health programmes. Ethnographic research can identify local features of the experience, meaning, and behaviour with reference to mental health that will determine success of programmes. It is expected that these

methods and the cultural epidemiological approach described here are helpful to develop relevant research strategies that ensure better clinical and social understanding of these problems, complimenting existing public health efforts.

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Chapter 4

Gender and the cultural context of common mental health problems in a primary health centre of an urban slum

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GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

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Gender and the cultural context of common mental health problems in a primary health centre of an urban slum

Abstract

Psychiatric epidemiology has examined the profile of mental disorders with respect to various socio-demographic descriptors (such as sex, age, and ethnicity). Many studies show sex-based differences with higher rates of some disorders for women (depression, somatoform, and dissociative disorders) and others for men (substance dependence and related disorders, sexual and gender-identity disorders, and impulse-control disorders). Such findings, however, usually lack the elaboration of social and cultural context required to show how sex-based differences are related to the social construction of gender, and how cultural contexts are relevant for community mental health practice and planning. Recent cultural epidemiological studies have highlighted the role and an approach for studying these cultural and gender contexts of illness. The study reported in this chapter aimed to clarify the social and cultural contexts of common mental health problems in a primary health centre of a slum community in Mumbai, with particular attention to gender-specific features. After screening positive for psychiatric symptoms with the Self-Reporting Questionnaire (SRQ), 120 patients in a community PHC were studied with a locally adapted EMIC interview to identify the distribution and nature (through narrative accounts) of patterns of distress, perceived causes, and prior help seeking. Diagnosis was also assessed with the SCID. Somatic symptoms were reported by nearly all patients, but women reported more. Other problems more frequently identified by women included suicidal thinking, marital problems, social isolation, tension and hostility. Men were more likely to explain their clinical problems with

reference to drugs and alcohol, work problems and unemployment. Analysis of the narrative context of these problems indicates the role of community stressors and community views of mental health problems, as reported in the previous chapter, and the value of mental health services to identify and treat these problems. Findings also indicate, however, the limitations of diagnostic evaluations that fail to consider and address the basis of mental health problems rooted in social experience, particularly in high-stress slum communities.

Introduction

Psychiatric epidemiology is concerned with relationships between the burden of mental illness and socio-demographic factors such as age, sex, and ethnicity. Numerous studies have indicated that more women than men are diagnosed with virtually all of the major and minor psychiatric disorders, including depressive disorders, somatoform disorders, and dissociative disorders (Pilgrim and Rogers, 1993; Rosse, 1999; Vazquez-Barquero et al., 1992; Desjarlais et al., 1995). However, studies have also shown that more men are diagnosed with substance related disorders, sexual disorders, cognitive disorders, and impulse control disorders (Gove and Gerkeen., 1977; Regier et al., 1993; Kesler et al., 1994; Piccinell et al., 1997).

Common mental disorders (CMDs) such as anxiety and depression have an estimated prevalence of about 15% in the general population (Goldberg and Huxley, 1992; Meltzer et al, 1995; Blaxter M, 1990), and have become a major concern in recent years (Goldberg & Huxley, 1992; Meltzer et al, 1995). CMDs are recognized in psychiatric practices, but are typically diagnosed as minor psychiatric disorders, neurotic disorders, psychoneurosis, or non-psychotic disorders. Several studies have recently highlighted CMDs as the most important cause of morbidity and a substantial source of disability in primary care settings (WHO, 1995; Ormel et al, 1994). In the United Kingdom, CMDs are responsible for one-third of days lost from work due to ill-health and one-fifth of consultations in general practice (Jenkins R, 1985; William et al, 1986). Low and middle income countries, including India, have reported high prevalence of CMDs in rural primary health clinics and urban general (Shamasunder et al, 1986; Hollifield et al, 1990; Araya et al, 1994).

Urban mental health: Role of gender and social context

The prevalence of mental disorders in cities differs from that in rural areas. In China, for example, schizophrenia is more prevalent in cities and learning disabilities are more prevalent in villages (Cooper and Sartorious, 1997). However, in the UK, depressive disorders and generalized anxiety disorders have a higher prevalence in urban areas than in rural (Meltzer et al, 1995). In industrialized countries, female gender, social, economic, and interpersonal factors are risk factors for CMDs (Warr, 1987; Gunell et al, 1995; Power et al, 1991; Eaton and Ritter,1988; Brown and Harris,1978). Our previous study demonstrated the significant impact of socio-cultural environment on emotional distress and mental health problems especially in relation to gender roles in urban slum community (Parkar et al, 2003). Patel et al. (1999) found that in India, Chile, Zimbabwe and Brazil CMDs were associated with female gender, low education and poverty.

It is largely assumed that women have higher rates of emotional problems than men and that the majority of women seek primary care, while men are more likely to get hospitalized for life-threatening symptoms (Adams and Benson.,1991; Legato and Colman.,1991).Women also suffer higher rates of sexual and physical abuse than men, for which they more commonly seek help in primary care settings (Livingston et al,1993; Walker E et al,1993;Van der kolk B,1994). The high rates of depressive disorders among women can largely be attributed to the social origins of depression (Dennerstein et al, 1993; Brown and Harris, 1978; Makosky, 1982; Belle, 1990).

Cultural epidemiological approach

Depression is associated with stressful life events such as those commonly

experienced by women including (Broadhead and Abas.,1998) domestic and violence, rigid cultural expectations. A broader understanding of the fundamental social and cultural process that cause these gender variations in the CMDs is needed. Recent cultural epidemiological research on various physical and psychiatric disorders illustrate that this approach suitable for community study of mental health concerns (Chowdhury et al, 2001;Raguram et al, 2001; Jadhav et al, 2001; Lee et al., 2001). Cultural epidemiology is the study of the nature and distribution of local representations of illness-related experience, meaning and behaviour (Weiss, 2001).

Aims and objectives

The aim of this study research was to identify local formulations of common mental health problems as they are known in the community, in contrast with common mental disorders as they are known to the health professionals . It also aimed to identify patterns of illness-related experience, meaning, and behaviour among patients with common mental health problems (CMHP) in a slum community, with reference to the gender-specific context of these problems.

Methods

This study was conducted in the primary health clinic (PHC) of the Malavani slum community, a large urban slum located in Mumbai, India. In general, PHC is a very popular choice in health care among Malavani inhabitants because it provides comprehensive treatment programmes, including free childhood vaccinations and other services to the adult population. Before the initiation of the study, approval was sought and granted from the institutional ethics committee of KEM Hospital in Mumbai. Adult patients (aged 18-60 years) attending outpatient services in the PHC

were included in the study. The study sample excluded patients with overt psychosis and substance use disorders at the time of enrollment in the study. After informed consent was obtained, every sixth patient was individually screened with a 20-item self-reported questionnaire (SRQ) that had been translated into Hindi and Marathi. Due to high illiteracy rate, it was not possible to ask patients to self administer the SRQ. Therefore, it was administered by two psychiatric resident doctors working in the community mental health program in PHC. Patients who satisfied ten out of twenty criteria on the SRQ were included in the study. Ninety female patients and 112 male patients were screened. Sixty females and 60 males were identified as having CMHPs and were included in the study sample.

Instruments

Self reported questionnaire (SRQ). Case identification was performed with the SRQ, developed by WHO in the early 1980s. This instrument has been used in many settings in the developing world. It is highly valid when compared to the diagnostic power of the psychiatric interview.

EMIC interview. In next phase of inquiry, patients who screened positive as having CMHPs were interviewed with an EMIC. An EMIC interview is a locally adapted semi- structured interview designed to elicit patients' illness-related experience, meaning, and behaviour. Based on prior ethnographic research, an EMIC operationalizes illness-related experience as patterns of distress (PD), meaning as perceived causes (PC), and help seeking behaviour (HS). EMIC interviews elicit both narrative prose for qualitative analysis and coded responses for quantitative analysis.

The EMIC used for this research was adapted from previous versions of the

EMIC that had been developed and used at the KEM Hospital for study of leprosy and DSH and elsewhere for mental disorders such as depression and schizophrenia (Parkar et al, 1998; Weiss et al, 1992; Raguram et al, 2001). The EMIC used for this study was guided by two sub-themes, mainly, the relationship between emotional life, social organization, and community perceptions of mental health problems (see also, Chapter 2 and 3).

SCID–IV. The SCID-IV is a semi-structured interview for the systematic assessment of psychiatric disorders with reference to DSM-IV criteria (First et al., 2001).

Analysis

All the interviews were recorded verbatim and responses were coded. Numerical and categorical data was entered into Epi Info and transferred into SAS for quantitative analysis. Narrative responses were entered in MAXqda for qualitative analysis. EMIC data was analysed to provide a descriptive and comparative account of patient's illness experiences, meanings, and behaviours, and compared by sex.

Results

Sample characteristics

The study consisted of 120 patients, 60 women with a mean age of 35, and 60 men with a mean age of 37.1. The majority of the sample was either Muslim or Hindu. 71.7% of women were Muslim and 25% were Hindu, and 55% of men were Muslim, and 43.2% were Hindu. A majority of women (86.7%) were married and 68.3% men were married. As seen in table 4.1, women in the sample were less educated than men were. Both men and women spoke either Hindi or Marathi.

Table 4.1 Sample characteristics of patients by sex

Sociodemographic features	Female (n=60)	Male (n=60)
AGE		
Mean age	35.0	37.1
Age range	18-55	22-60
MOTHER TONGUE (%)		
Marathi	13.3	18.3
Hindi	74.7	64.7
Gujarati	3.3	3.3
South Indian	4.9	8.3
Other	3.3	5.0
RELIGION (%)		
Hindu	25.0	43.2
Muslim	71.7	55.0
Christian	0.0	1.7
Other	3.3	0.0
MARRIAGE (%)		
Never married	1.7	15.0
Married	86.7	68.3
Separated and divorced	5.0	6.7
Remarried	0.0	1.7
Widowed	6.7	8.3
EDUCATION (%)		
None	55.0	31.7
Primary	8.4	16.7
Some Secondary	30.0	35.0
SSC	6.7	8.3
HSC	0.0	6.6
Degree	0.0	1.7

Clinical profile

Depressive disorders (table 4.2) were more frequently represented among women (90.0%) in the sample than among men (75.0%). Major depressive disorders and anxiety disorders were equally distributed between the sexes, but dysthmic

disorders (28.3%) and panic disorders were somewhat more commonly diagnosed among women. Significantly more men (15% of men, no women) were diagnosed with substance use disorders (SUDs). Although patients with overt substance use disorders were screened out of the study, these men reported being in remission for SUDs(mainly alcohol).

Table 4.2: Diagnosis and sex of patients with Common mental disorders (%)

Diagnosis	Women n=60	Men n=60	Total n=120
Adjustment disorder	**3.3**	**5.0**	**4.2**
With anxiety	1.7	0.0	0.8
With depression	1.7	5.0	3.3
Anxiety disorders	**25.0**	**31.7**	**28.3**
Generalized anxiety disorder	3.3	3.3	3.3
Anxiety disorder, general medical condition	1.7	3.3	2.5
Panic disorder	10.0	6.7	8.3
Agoraphobia without panic	0.0	1.7	0.8
Obsessive-compulsive disorder	1.7	0.0	0.8
Social phobia	1.7	1.7	1.7
Anxiety disorder, NOS	6.7	15.0	10.8
Depressive disorders	**90.0**	**75.0**	**82.5**
Major depressive disorder	56.7	55.0	55.8
Dysthymic disorder	28.3	18.3	23.3
Depressive disorder, NOS	5.0	1.7	3.3
Somatoform Disorders	**3.3**	**5.0**	**4.2**
Undifferentiated somatoform disorder	3.3	5.0	4.2
Substance use disorders	**0.0**	**15.0**	**7.5**
Alcohol dependence, remission	0.0	11.7	5.8*
Substance dependence, opioid	0.0	1.7	0.8
Substance dependence, canabis	0.0	1.7	0.8
V-Code	**1.7**	**0.0**	**0.8**
V-Code, bereavement	1.7	0.0	0.8

*$p<.05$, Fisher's exact test

The total number of diagnoses is greater than the number of subjects because of a dual diagnosis for some patients. Categories of adjustment disorders, V-code, were exclusive of all other diagnoses.

Patterns of distress

As grouped categories of distress (table 4.3), significantly more women than men reported anxiety and suicidality (p<.01) and significantly more men reported addictive behaviours (p<.01). Somatoform symptoms frequently reported by both men and women, and were most commonly (98.3 % of all respondents) identified spontaneously. Depressive symptoms were also frequently reported by both men and women (95% of women and 98.3% of men). Social and interpersonal distress was also commonly reported by both men and women, typically more upon probe.

For the individual categories of distress, crying, hostility, headache, heaviness in one's body, worries, and social isolation were significantly more common among females. In addition, significantly more women (70%, p=.01) than men had suicidal thoughts. Alcohol was significantly more distressing for men than it was for women (no women reported this category).

Table 4.3: Reported categories of Distress by sex (%)

Items and Clusters	Female (N=60)		Male (N=60)		Total (N=120)		P-Value*
	Spont	Probed	Spont	Probed	Spont	Probed	
I. MOOD	**68.3**	**26.7**	**55.0**	**43.3**	**61.7**	**35.0**	**0.20**
Sadness	56.7	33.3	38.3	48.3	47.5	40.8	0.06
Crying	36.7	36.7	5.0	31.7	20.8	34.2	<0.001
Loss of interest	23.3	35.0	25.0	33.3	24.2	34.2	0.92
Hostility	46.7	30.0	21.7	51.7	34.2	40.8	0.03
Elation	1.7	1.7	0.0	1.7	0.8	1.7	0.56
II. SOMATOFORM	**98.3**	**1.7**	**98.3**	**1.7**	**98.3**	**1.7**	**1.00**
Fatigue	83.3	10.0	75.0	18.3	79.2	14.2	0.30
Physical pain	81.7	8.3	73.3	16.7	77.5	12.5	0.33
Chakkar(giddy)	55.0	18.3	41.7	26.7	48.3	22.5	0.22
Headache	63.3	25.0	40.0	20.0	51.7	22.5	0.00
Burning	20.0	10.0	23.3	10.0	21.7	10.0	0.67
Cold extremities	21.7	15.0	11.7	10.0	16.7	12.5	0.07
Heaviness in body	45.0	21.7	18.3	18.3	31.7	20.0	0.00
Tingling	38.3	23.3	23.3	28.3	30.8	25.8	0.12
Vat	3.3	1.7	1.7	1.7	2.5	1.7	0.65
Other somatic	25.0	5.0	23.3	5.0	24.2	5.0	0.84
Sleep dist	45.0	25.0	33.3	40.0	39.2	32.5	0.53
III. PSYCHOSIS	**1.7**	**8.3**	**0.0**	**8.3**	**0.8**	**8.3**	**0.74**
Delusional	0.0	3.3	0.0	1.7	0.0	2.5	0.57
Hallucinations	0.0	3.3	0.0	1.7	0.0	2.5	0.57
Paranoid	1.7	6.7	0.0	5.0	0.8	5.8	0.46
Abnormal violent	0.0	0.0	0.0	0.0	0.0	0.0	1.00

Items and Clusters	Female (N=60)		Male (N=60)		Total (N=120)		P-Value*
	Spont	Probed	Spont	Probed	Spont	Probed	
IV. ANXIETY	**73.3**	**25.0**	**56.7**	**36.7**	**65.0**	**30.8**	**0.05**
Worries	61.7	30.0	38.3	40.0	50.0	35.0	0.01
Tension	65.0	30.0	46.7	38.3	55.8	34.2	0.03
Fears phobias	1.7	11.7	6.7	1.7	4.2	6.7	0.46
Obsessive	0.0	5.0	0.0	1.7	0.0	3.3	0.32
Palpitations	26.7	31.7	16.7	35.0	21.7	33.3	0.28
Tremulousness	10.0	20.0	5.0	15.0	7.5	17.5	0.19
Dryness of mouth	21.7	26.7	16.7	18.3	19.2	22.5	0.17
V. SUICIDALITY	**10.0**	**63.3**	**3.3**	**45.0**	**6.7**	**54.2**	**0.00**
Suicidal thoughts	6.7	63.3	3.3	41.7	5.0	52.5	0.01
Suicidal plans	3.3	5.0	0.0	6.7	1.7	5.8	0.70
Suicidal act	3.3	1.7	0.0	1.7	1.7	1.7	0.31
VI. ADDICTIVE BEHAVIOUR	**6.7**	**13.3**	**8.3**	**35.0**	**7.5**	**24.2**	**0.01**
Tobacco	3.3	11.7	6.7	23.3	5.0	17.5	0.05
Alcohol	0.0	0.0	1.7	15.0	0.8	7.5	0.00
Cannabis charas	0.0	0.0	1.7	1.7	0.8	0.8	0.16
Brown sugar gard	0.0	0.0	1.7	0.0	0.8	0.0	0.33
Gutka mawa	3.3	1.7	0.0	3.3	1.7	2.5	0.63
VII. MISCELLANEOUS	**50.0**	**38.3**	**40.0**	**35.0**	**45.0**	**36.7**	**0.11**
Eating disturbance	21.7	23.3	21.7	30.0	21.7	26.7	0.59
Impaired memory	11.7	31.7	8.3	25.0	10.0	28.3	0.26
Marital problems	8.3	23.3	10.0	5.0	9.2	14.2	0.06
Other interpersonal	1.7	6.7	0.0	1.7	0.8	4.2	0.10
Disturbed sense of self	1.7	1.7	1.7	3.3	1.7	2.5	0.66
Social isolation	6.7	20.0	1.7	8.3	4.2	14.2	0.02
Sexual problem	0.0	10.0	8.3	8.3	4.2	9.2	0.23
Semen loss *Dhat*	10.0	3.3	5.0	5.0	7.5	4.2	0.54
Possession, trance	1.7	0.0	0.0	0.0	0.8	0.0	0.33
Dangerousness to others	0.0	1.7	0.0	0.0	0.0	0.8	0.33
Other	1.7	1.7	6.7	3.3	4.2	2.5	0.14

*Wilcoxon test.

When queried about the most troubling feature of their distress (table 4.4), significantly more men specified ‘worry’, although few patients overall selected this category.

Table 4.4: Most important categories of distress by sex (%)

Items and clusters	Female (N=60)	Male (N=60)	Total (N=120)	P-Value*
I. MOOD	**0.0**	**1.7**	**0.8**	**1.00**
Sadness	0.0	1.7	0.8	1.00
II. SOMATOFORM	**71.7**	**70.0**	**70.8**	**1.00**
Fatigue	5.0	8.3	6.7	0.72
Physical pain	31.7	30.0	30.8	0.84
Chakkar	5.0	0.0	2.5	0.24

Items and clusters	Female (N=60)	Male (N=60)	Total (N=120)	P-Value*
Headache	18.3	10.0	14.2	0.19
Tingling	1.7	1.7	1.7	1.00
Other somatic	8.3	16.7	12.5	0.16
Sleep disturbances	1.7	3.3	2.5	1.00
IV. ANXIETY	**18.3**	**15.0**	**16.7**	**0.62**
Worries	0.0	3.3	1.7	0.50
Tension	16.7	8.3	12.5	0.16
Fears phobias	0.0	1.7	0.8	1.00
Palpitations	1.7	1.7	1.7	1.00
VI. ADDICTIVE BEHAVIOURS	**1.7**	**1.7**	**1.7**	**1.00**
Cannabis charas	0.0	1.7	0.8	1.0
Gutka mawa	1.7	0.0	0.8	1.00
VII. MISCELLANEOUS	**8.3**	**11.7**	**10.0**	**0.54**
Eating disturbance	0.0	1.7	0.8	1.00
Marital problems	1.7	1.7	1.7	1.00
Semen loss *Dhat*	3.3	6.7	5.0	0.68
Other	3.3	1.7	2.5	1.00

*Fisher's Exact test.

Both male and female patients commonly reported somatic distress, and in their narrative accounts, they often used the opportunity as a platform to talk about other features of their illness, mainly, social and emotional distress. Women, for example, frequently reported suffering from headaches or having a heaviness of the body, which led to them talk about social problems, inabilities to carry on activities, anger and hostility related to living conditions, and so forth. One such woman stated:

> I get giddiness (*chakkar*), swelling in legs, and have menstrual problem. I feel blankness in head, numbness in body (*sunn*). I want to go away from home. I am fed up from household chores. I become irritated easily. I think a lot about my son and about his further study. I have a lot of tension about so many things. When I think a lot than I feel heaviness in body (*zad Ho gayi hu*) continuous headache and burning sensation, sometime my mouth becomes dry. I always feel isolated.

Another woman narrated her personal suffering in physical language and

spontaneously linked the physical distress with the social distress. She reported,

> I have been feeling giddiness (*chakkar*), sadness, anger, irritability, and weakness. There is tingling (*mungi*) in my body. I also feel a lot of physical pain and headache (s*ir udta hi*). Actually, nowadays I have many quarrels with my in-laws. My mother in-law abuses me. I am married and am the mother of 3 year-old son. So I am seriously tense about money, home, and about my child. I think a lot about these things, so I have developed negative feeling about future. Suicidal thoughts come in my mind. I was regular victim of physical and verbal violence. (*gali khaya mar bhi khati hu*).

In their narrative accounts, men commonly reported feeling mentally tired from issues such as financial problems, unemployment, and past alcoholism. They reported feeling distraught by the inability to accomplish familial duties and because of conflicts with their spouses. One such male reported,

> I feel tired all the time, I find difficult to move around, I have no work so I am tensed. I am a driver but I have not found any work since 3-4 years. I get breathless. I cannot eat food because I do not feel like eating. I feel bored (*kantala*) because I have no work. I feel irritable on small things. I get up at midnight and then I don't get sleep. I sleep only for one or two hours. I fight with my wife because I eat tobacco and she does not like it. We have no money so we are all the time agitated. I have increased my tobacco consumption since I lost job.

Another man expressed the extreme pressure of familial responsibilities, which have resulted in feelings of isolation and suicidality; he reported,

> I am eldest son in my family. So I am only earning member in my

family. I think about my parents. As I have one daughter and eight brothers and sisters, I have big responsibility on my shoulders. My younger brother he has expired 11 years back. Even now I miss him. He was my support. Sometimes I feel numbness (*sunna*) and palpitation. When I feel lonely and think about burden of family responsibility then I want to commit suicide. (*zimmedari ka ahsas muze daba deta hi*). I think that I have weakness because of tension and work.

Perceived causes

When queried for the cause of their mental health problems (table 4.5), men frequently reported the group of ingestion-related causes, including alcohol and drugs, while women more often reported emotional causes.

For individual categories, a number of gender differences were noted. Alcohol and drugs, work, unemployment, and childhood abuse were significantly more common causes among men. Significantly more women reported that tension, frustration, problems with in-laws, family illness, weakness, sexual abuse, and menstrual problems were the cause of their CMHPs.

Table 4.5: Reported perceived causes by sex (%)

Items and Clusters	Female (N=60)		Male (N=60)		Total (N=120)		P-Value*
	Spont	Probed	Spont	Probed	Spont	Probed	
I. INGESTION	**13.3**	**8.3**	**23.3**	**18.3**	**18.3**	**13.3**	**0.02**
Food, water	5.0	1.7	3.3	3.3	4.2	2.5	0.99
Alcohol	0.0	6.7	6.7	13.3	3.3	10.0	0.03
Smoking	1.7	0.0	3.3	1.7	2.5	0.8	0.32
Drug	6.7	0.0	18.3	11.7	12.5	5.8	0.00
Prescribed med	1.7	0.0	1.7	1.7	1.7	0.8	0.57
II. INJURY-MEDI-SURG	**70.0**	**5.0**	**53.3**	**6.7**	**61.7**	**5.8**	**0.06**
Injury	11.7	0.0	8.3	3.3	10.0	1.7	0.95
Overwork	25.0	5.0	16.7	3.3	20.8	4.2	0.21

Items and Clusters	Female (N=60)		Male (N=60)		Total (N=120)		P-Value*
	Spont	Probed	Spont	Probed	Spont	Probed	
Prior illness	13.3	3.3	18.3	3.3	15.8	3.3	0.48
Post-ligation	1.7	1.7	0.0	0.0	0.8	0.8	0.16
Weakness	58.3	8.3	36.7	6.7	47.5	7.5	0.01
Nerves	13.3	5.0	11.7	1.7	12.5	3.3	0.49
Pregnancy	6.7	0.0	1.7	0.0	4.2	0.0	0.17
III. SOCIAL	**80.0**	**16.7**	**66.7**	**20.0**	**73.3**	**18.3**	**0.07**
Failed romance	1.7	1.7	0.0	1.7	0.8	1.7	0.56
Dowry problem	1.7	3.3	0.0	0.0	0.8	1.7	0.08
Marital problem	25.0	3.3	13.3	5.0	19.2	4.2	0.17
In-law problem	16.7	5.0	6.7	1.7	11.7	3.3	0.04
0other family problem	8.3	1.7	6.7	8.3	7.5	5.0	0.47
Family illness	8.3	3.3	0.0	1.7	4.2	2.5	0.03
Work problem	11.7	13.3	30.0	11.7	20.8	12.5	0.03
Unemployment	10.0	3.3	21.7	10.0	15.8	6.7	0.02
Other interpersonal	0.0	0.0	0.0	0.0	0.0	0.0	1.00
Migration	5.0	0.0	3.3	0.0	4.2	0.0	0.65
Bereavement	31.7	6.7	13.3	13.3	22.5	10.0	0.09
Poverty, financial	45.0	28.3	40.0	20.0	42.5	24.2	0.27
Other stress, loss	3.3	1.7	3.3	3.3	3.3	2.5	0.71
IV. ENVIRONMENTAL	**1.7**	**0.0**	**0.0**	**0.0**	**0.8**	**0.0**	**0.33**
Demolition of home	1.7	0.0	0.0	0.0	0.8	0.0	0.33
Water, sanitation	0.0	0.0	0.0	0.0	0.0	0.0	1.00
V. VICTIMIZATION	**1.7**	**6.7**	**8.3**	**8.3**	**5.0**	**7.5**	**0.15**
Childhood abuse	0.0	1.7	8.3	8.3	4.2	5.0	0.00
Victim of violence	1.7	5.0	1.7	3.3	1.7	4.2	0.71
Sexual abuse	0.0	3.3	0.0	0.0	0.0	1.7	0.16
VI. MAGIC-SPIRITS	**1.7**	**5.0**	**0.0**	**5.0**	**0.8**	**5.0**	**0.69**
Sorcery	0.0	3.3	0.0	3.3	0.0	3.3	1.00
Demons	1.7	1.7	0.0	1.7	0.8	1.7	0.56
VII. DEED-HABIT-KARMA	**1.7**	**6.7**	**5.0**	**1.7**	**3.3**	**4.2**	**0.78**
Poor health habits	0.0	0.0	0.0	1.7	0.0	0.8	0.33
Bad deed	1.7	1.7	5.0	0.0	3.3	0.8	0.64
Bad deed previous life	0.0	5.0	1.7	3.3	0.8	4.2	0.99
VIII. EMOTIONAL	**78.3**	**15.0**	**53.3**	**15.0**	**65.8**	**15.0**	**0.00**
Emotional distress	21.7	30.0	13.3	25.0	17.5	27.5	0.12
Tension	76.7	16.7	43.3	23.3	60.0	20.0	<0.01
Frustration	33.3	28.3	28.3	8.3	30.8	18.3	0.04
Humiliation	20.0	23.3	23.3	6.7	21.7	15.0	0.31
IX. HEREDITY	**0.0**	**0.0**	**1.7**	**0.0**	**0.8**	**0.0**	**0.33**
Heredity	0.0	0.0	1.7	0.0	0.8	0.0	0.33
X. SEXUAL-REPROD	**15.0**	**5.0**	**15.0**	**5.0**	**15.0**	**5.0**	**1.00**
Premarital sex	0.0	0.0	0.0	1.7	0.0	0.8	0.33
Adultery	0.0	0.0	0.0	1.7	0.0	0.8	0.33
Sex with csw	0.0	0.0	0.0	1.7	0.0	0.8	0.33
Semen loss	10.0	1.7	8.3	3.3	9.2	2.5	0.98
Masturbation	0.0	0.0	1.7	0.0	0.8	0.0	0.33
Sexual weakness	0.0	0.0	8.3	1.7	4.2	0.8	0.01
Menstrual problem	5.0	3.3	0.0	0.0	2.5	1.7	0.02
XI. HEAT/COLD/AYURVED	**13.3**	**18.3**	**15.0**	**15.0**	**14.2**	**16.7**	**0.92**
Heat, cold in body	5.0	1.7	0.0	5.0	2.5	3.3	0.66
Vayu	5.0	3.3	0.0	3.3	2.5	3.3	0.23
Pitta	5.0	8.3	6.7	3.3	5.8	5.8	0.62
Kapha	0.0	11.7	13.3	6.7	6.7	9.2	0.14
XII. FATE	**8.3**	**31.7**	**11.7**	**13.3**	**10.0**	**22.5**	**0.16**
Fate,will of god	8.3	31.7	11.7	13.3	10.0	22.5	0.16
XIII. MISCELLANEOUS	**1.7**	**5.0**	**0.0**	**5.0**	**0.8**	**5.0**	**0.69**

Items and Clusters	Female (N=60)		Male (N=60)		Total (N=120)		P-Value*
	Spont	Probed	Spont	Probed	Spont	Probed	
Contamination, infection	0.0	1.7	0.0	0.0	0.0	0.8	0.33
Other	1.7	1.7	0.0	3.3	0.8	2.5	0.99
Cannot say	0.0	1.7	0.0	1.7	0.0	1.7	1.00

*Wilcoxon test.

Men and women commonly reported social and emotional causes as the most important group of perceived causes (table 4.6). For individual most important PCs, alcohol and drug use was reported significantly more often by males and problems with in-laws and migration were reported by significantly more female patients. Migration to the slum community was perceived very negatively by women because life in this setting entails enormous hardships, a constant struggle for money and alienation from their family network.

Table 4.6: Most important perceived causes by sex (%)

Items and clusters	Female (N=60)	Male (N=60)	Total (N=120)	P-Value*
I. INGESTION	**1.7**	**8.3**	**5.0**	**0.21**
Alcohol	0.0	3.3	1.7	0.50
Smoking	0.0	1.7	0.8	1.00
Drug	0.0	3.3	1.7	0.50
Prescribed med	1.7	0.0	0.8	1.00
II. INJURY-MEDICAL-SURGICAL	**16.7**	**18.3**	**17.5**	**1.00**
Injury	0.0	5.0	2.5	0.24
Overwork	1.7	3.3	2.5	1.00
Prior illness	5.0	5.0	5.0	1.00
Post ligation	3.3	0.0	1.7	0.50
Weakness	6.7	3.3	5.0	0.68
Pregnancy	0.0	1.7	0.8	1.00
III. SOCIAL	**43.3**	**41.7**	**42.5**	**1.0**
Dowry problem	1.7	0.0	0.8	1.00
Marital problem	8.3	5.0	6.7	0.72
In-law problem	3.3	0.0	1.7	0.50
Other family problem	1.7	3.3	2.5	1.00
Family illness	1.7	0.0	0.8	1.00
Unemployment	3.3	10.0	6.7	0.27
Migration	3.3	0.0	1.7	0.50
Bereavement	8.3	8.3	8.3	1.00
Poverty, financial	10.0	10.0	10.0	1.00
Other stress, loss	1.7	5.0	3.3	0.62
VI. MAGIC-SPIRITS	**0.0**	**1.7**	**0.8**	**1.00**
Sorcery	0.0	1.7	0.8	1.00
VII. DEEDS-HABITS-KARMA	**0.0**	**1.7**	**0.8**	**1.00**
Bad deed	0.0	1.7	0.8	1.00

Items and clusters	Female (N=60)	Male (N=60)	Total (N=120)	P-Value*
VIII. EMOTIONAL	**25.0**	**15.0**	**20.0**	**0.25**
Emotional distress	3.3	1.7	2.5	1.00
Tension	21.7	11.7	16.7	0.22
Humiliation	0.0	1.7	0.8	1.00
X. SEXUAL-REPRODUCTIVE	**5.0**	**5.0**	**5.0**	**1.00**
Premarital sex	0.0	1.7	0.8	1.00
Semen loss	3.3	1.7	2.5	1.00
Masturbation	0.0	1.7	0.8	1.00
XI. HEAT-COLD/AYURVEDIC	**3.3**	**1.7**	**2.5**	**1.00**
heat, cold in body	0.0	1.7	0.8	1.00
vayu-wind	1.7	0.0	0.8	1.00
pitta	1.7	0.0	0.8	1.00
XII. FATE	**1.7**	**1.7**	**1.7**	**1.00**
Fate, will of god	1.7	1.7	1.7	1.00
XIII. MISCELLANEOUS	**3.3**	**1.7**	**2.5**	**1.00**
Other	3.3	1.7	2.5	1.00

*Fisher's exact test.

Many of the married women in the sample reported that their problems had origin in their marital and social lives. Married women commonly reported frustration and tension caused by problems with in-laws, husbands, and financial problems. For these women, tension became an uncomplicated way to communicate the nature of their problem and the related psychological suffering. In one example, a young woman reported that her problems were simultaneously interpersonal, physical, and financial; she stated,

> I think tension is main cause of my pain. Because of tension, I am finding difficulty in daily routine work. My relation with my husband is not normal. I was tuberculosis (TB) patient. So sometimes it comes in my mind that this problem might be TB. I think that this problem can be due to over work or a clash with in-laws, especially my mother in law. She beats me regularly. But financial problems are the main reason because I am very much worried about our poor status in the society.

Another woman reflected on the synergistic qualities of her problems; she

stated, “Tension is the main cause of my problem. I feel exertion, weakness, I feel frustrated, deprived. I have so much tension about family, illness, and poverty.”

Men also explained the nature of their problems in the context of social and financial strains. Unemployment and difficulties at work often resulted in frustration and insecurity, and ultimately, alcoholism. Many men reported unemployment, financial troubles, and the eventual alcoholism lessens their prestige in the eyes of their family and society, making them feel demoralised. One man reported,

> Since I had no family, I got into bad company and I used to consume lot of alcohol. Ganja and also cannabis(*charas*) occasionally. I smoke a lot, so I think I keep getting TB. I have nothing left in my life to live for. I think that I contracted TB, because I used to take a lot of alcohol and heroin (*gard*). I spend all my money on this and neglected my food. So I have become weak. I have completely neglected myself after my wife's death.

Help seeking (HS)

The majority of men and women sought help at PHC services (65% of women and men), private general practitioners (53.3% of women, 46.6% of men), or government hospitals (36.7% of women, 31.7% of men) for their common mental health problems. Significantly more men than women did not seek any help at all for their problems (table 4.7). Few patients sought care from a mental health specialist.

Table 4.7: Help seeking by sex (%)

Type of help	Female		Male		Total		P-Value*
	Spon	Prob	Spon	Prob	Spon	Prob	
Friends and family	3.3	3.3	8.3	5.0	5.8	4.2	0.22
Community leader-social worker	1.7	0.0	0.0	0.0	0.8	0.0	0.33
Druggist pharmacy for advice	8.3	0.0	3.3	0.0	5.8	0.0	0.25
Primary health centre	56.7	8.3	63.3	1.7	60.0	5.0	0.64
Government/BMC hospital	35.0	1.7	30.0	1.7	32.5	1.7	0.56
Private general practitioner	45.0	8.3	43.3	3.3	44.2	5.8	0.63
Mental health specialist	1.7	0.0	1.7	0.0	1.7	0.0	1.00
Other specialist	5.0	1.7	3.3	0.0	4.2	0.8	0.42
Ayurveda, unani	8.3	0.0	1.7	1.7	5.0	0.8	0.23
Homeopath	0.0	1.7	5.0	0.0	2.5	0.8	0.30
Local herbal healer	1.7	1.7	1.7	0.0	1.7	0.8	0.57
Faith healer	8.3	6.7	5.0	8.3	6.7	7.5	0.76
Astrologer	0.0	1.7	0.0	0.0	0.0	0.8	0.33
Healing temple	15.0	3.3	10.0	1.7	12.5	2.5	0.32
VD, Sex clinic	0.0	0.0	0.0	1.7	0.0	0.8	0.33
Other specialist	0.0	0.0	0.0	1.7	0.0	0.8	0.33
None	5.0	1.7	11.7	8.3	8.3	5.0	0.04

*Wilcoxon test.

Patients primarily sought care from biomedical practitioners to seek relief from their somatic symptoms alone; many reported that they felt unable to take steps against the other social, emotional, and financial problems associated with their condition. Mainly they sought symptomatic helps for pain and aches. One woman reported seeking care following episodes of domestic violence,

> I was helpless about my in-laws and husband. After all the beating, I used to go to the doctor to take pain-killers. When there is so much body pain; then you can't delay going to the doctor.

Many patients' help seeking was initiated because of physical pain alone rather than emotional distress, primarily because they had become accustomed to the latter; one woman explained,

> I went to doctor because I thought I had a heart problem that was causing me difficulty in breathing and palpitations. My tension and

> worries are due to my husband being irresponsible all the time. But my breathing difficulty, I think is due to a heart problem. Not due to tension – or else I should have had it long back, as I always had tension.

Discussion

Although most CMDs such as depression and anxiety are well-represented among primary care patients, these disorders are rarely identified and diagnosed. This study showed that CMDs in are common problems among PHC patients an in urban slum community. Major depressive disorders were the most common presentation among PHC out-patients in the sample. Among women in particular, dysthymic disorders were common, which has also been found in several other studies (Weissman and Klerman et al, 1977, 1985, 1992; Bland et al, 1988; Canino et al, 1987; Wells et al, 1989). Fifteen percent of men were diagnosed with substance use disorders, particularly in remission alcohol dependence. In our previous work, we have reported how environmental and social contexts shape the local illness experience of CMHPs (Parkar et al, 2003). The current study indicates that the social, emotional, and environmental contexts also shape the experience of CMHPs in an urban slum. These findings also indicate the need to understand the ways in which these problems are locally expressed, rather than identifying them by diagnosis alone.

Social and clinical considerations

Men and women experience CMHPs differently in terms of their illness experience, its meaning, and associated illness behavior. The frequency with which patients—particularly women—expressed suicidal ideations revealed the nature and

extent of illness-related suffering. Similar findings have been found in North America and Europe (Angst et al, 1992; Bronisch and Witchen, 1994; Mosciki et al, 1988). Suicidality was elicited from patients in the study sample considerably more upon probed query, clarifying the need for specific probing of suicidal behaviors for effective suicide prevention strategies in the clinical setting of community mental health programmes.

Somatic complaints were frequently reported among patients in the sample. Studies from China have also demonstrated that patients commonly present to clinics with overt physical distress, but report emotional symptoms only after being probed for them (Cheung et al, 1981). This highlights the apparent fact that people are largely motivated to seek clinical help for somatic complaints, rather than emotional complaints (Raguram et al, 2001). However, this study identified that patients commonly sought care for physical complaints, but expressed these somatic symptoms in terms of their social and emotional context. Women, for example, frequently reported heaviness and headache as paradigms of their financial, social, and family-related problems. Our findings highlight the importance of the cultural and social context of illness in the study of CMHPs and in clinical practice in the PHC setting.

In addition, our findings also identify the importance of the gendered context of CMHPs. Our findings show that although men are equally afflicted by depressive symptoms associated with CMHPs, they are less likely than women to express these symptoms spontaneously, but rather upon probe. This finding suggests that because of their expected gender roles, men are more likely to try to mask their depression or are unable to express depressive symptoms. It is also possible that depression among men might be more likely to manifest itself in other forms of behavioural

problems such as addictive behavior and anti-social personality disorders. Such factors can lead to underreporting of CMDs among men than in epidemiological surveys which generally do not probe for these symptoms. Symptoms of CMDs such as sadness, crying, worries, and tension are conventionally accepted behviours in women, but are not considered as appropriate masculine behaviour.

Hostility is typically recognized as acceptable male behaviour but is neither expected nor accepted from women. However, female respondents in our sample frequently reported hostile emotions both spontaneously and upon probe. This finding suggests that poor women in urban slums may experience greater feelings of hostility because of their repressed, subordinate status, lack of autonomy, and lack of empowerment.

Women in our study sample frequently identified problems with their in-laws, sexual abuse, family illness, tension, and frustration as factors that caused their CMHPs. These findings underscore the social origins of distress, particularly in an urban slum context. Unemployment, financial problems, drugs and alcohol were problems characteristically associated with men, and resulted in personal distress with reference to their failure to perform conventional masculine duties, social ostracizing, lack of self-esteem, and hopelessness. Addictive behaviors and personality disorders in men are frequently marginalized in mental health care (Barnett et al, 1987). Conforming to the expected male role might not only be oppressive, but psychologically damaging as well (Pleck, 1981).

Clinical implications of cultural framework of gender and CMHP

Given the local variability and gender-specific nature of CMHPs, psychiatric approaches to their identification will not be universally applicable. Emerging trends

to acknowledge and integrate a cultural epidemiological framework into understanding psychiatric problems, particularly in a gendered context, is timely. The need to consider gender-specific issues such as women's victimization and addictive problems among men is an important public health interest.

Future development in policy recommendations and research

This research emphasized the need to broaden current clinical approaches to recognize the social determinants of CMHPs. Preventive public health policies should focus on the broad determinants of mental health, such as economic opportunity and development, rather than solely focusing on mental health services. Issues related to gender-specific social problems should be integrated into preventive mental health policies. Community strengthening and economic empowerment should be central to preventative activities at the community level, and educational campaigns should focus on the role of social factors in determining mental health.

The gender-specific features of CMHPs are an important area of inquiry for research because they are associated with poverty, lower education, and women. Further research should aim to understand how the urban slum environment influences the incidence of psychiatric problems, and should also investigate the apparent resilience of some against developing psychiatric problems in this context.

Conclusion

This study identified the need to consider the social determinants of CMHPs in an urban slum community. It underscored the contextual features of gender differences regarding CMHPs, and identified the importance of understanding

patients’ local experiences, meanings, and behaviours to tailor appropriate community mental health services and policies.

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Chapter 5

Clinical and socio-cultural dimensions of deliberate self-harm in Mumbai, India

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GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

Submitted to *Suicide and Life-Threatening Behavior*

Clinical and socio-cultural dimensions of deliberate self-harm in Mumbai, India

Abstract

Patients' accounts complement psychiatric assessment of deliberate self-harm, providing a framework for cross-cultural comparison. This study identified and related psychiatric disorders and socio-cultural features of DSH. SCID diagnostic interviews and a locally adapted EMIC interview were used to study 196 patients after DSH at a general hospital in Mumbai, India. Major depression was the most common diagnosis in the sample (38.8%), followed by substance use disorders (16.8%), but 44.4% of patients did not meet criteria for an enduring Axis-I disorder (no diagnosis, V-code, or adjustment disorder). For them, social pain and psychache did not fulfil criteria for enduring psychiatric disorders.

Introduction

Deliberate self-harm is a serious mental health problem, accounting for an estimated 877,000 suicides in the year 2002 (WHO, 2003). According to the most recently available data for India, mortality from suicide in the year 2000 totalled 108,593, with a corresponding rate of 10.6 per 100,000. In the city of Mumbai 1,086 suicides were recorded (Government of India, 2002). Although rates are difficult to determine because of ambiguities in the catchment area reported, it is clear from these data that preventing suicide and deliberate self-harm (DSH) are high priorities for mental health policy in India, as they are throughout the world (Goldsmith et al.,2002; WHO, 2001).

Research also suggests that about half of the people who ultimately kill themselves have a history of DSH, and evidence suggests that 20-25% of persons who die by suicide have a history of DSH within the previous year (Foster et al., 1997). Estimates suggest that reducing suicide risks in the population with a history of DSH by 25% would reduce overall suicide rates by up to 5.8% (Lewis et al., 1997). In addition to the priority of reducing mortality from suicide, suicidal behaviour also indicates priority issues associated with self-harm that concern clinical practice and mental health policy.

In India, the influence of cultural values, social stigma, incentives to avoid medical-legal complications, and a poor infrastructure for documentation in some areas all contribute to serious underestimates of suicide and deliberate self-harm. Persistent media reports and a heavy clinical burden, however, indicate the priority of suicide and suicidal behaviour. At the KEM Hospital, Mumbai, the largest tertiary-care hospital in the country's largest city, 428 patients were referred to psychiatry for

deliberate self-harm in 2003 out of a total of 6000 new patients coming to the psychiatry outpatient clinic for all clinical problems.

Recent literature has also emphasized the importance of cultural differences in the motivation of suicidal behaviour. Questions have arisen about differences in the relative emphasis on psychopathology in much of the Western literature, which typically attributes 90% of suicides to mental disorders (Goldsmith, 2002), and contradictory findings in Asian studies, which emphasize social contexts and stressors. Studies in India, such as the psychological autopsies involving family survivor interviews of 30 suicides in Bangalore, reported by Gururaj and Isaac (2001), found evidence for a diagnosis of depression (and no other psychiatric diagnoses) in only 45% of people who died by suicide. Their study involved in-depth interviews with family survivors, examination of all available police records and other relevant data. Findings emphasized social stressors, including financial problems, family conflicts, illicit relationships of a spouse, serious illness, and frustrated teenage romance as specified cases.

Other Asian studies have long emphasized such stressors, rather than psychopathology in India. Bhatia and colleagues (1987) emphasized other factors instead: humiliation, shame, economic hardships, and family discord. Gehlot and Nathavat (1983) identified social stressors arising from family conflict as the most important contributor to suicidal behaviour in India. Research in China also emphasizes the importance of social rather than psychopathological contributions to suicidal behaviour (Zhao, 2000; Zhang et al., 2000). The relative differences and the importance of understanding local determinants of suicidal behaviour highlight the need for cross-cultural studies attentive to socio-cultural and psychopathological determinants of suicide.

Aims and objectives

The present research responds to the need for integrated study of suicidal behaviour from complementary socio-cultural and clinical perspectives. Combining cultural epidemiological and clinical psychiatric approaches, this research aimed to identify and examine the relationship between clinical features and patient-perceived determinants of suicidal behaviour. Assessment of these complementary frameworks required integration of anthropological and epidemiological frameworks and methods, constituting a transdisciplinary synthesis on which development of cultural epidemiology has been based (Weiss, 2001; Weiss,1997).This line of inquiry is concerned with patients' views of the problems, studying problem-related experience, meaning, and behaviour with reference to patterns of distress, perceived causes, and help seeking. It is also concerned with the relationship between such findings and practical clinical and population-based health outcomes, based on standard clinical and basic epidemiological assessments.

Methods

The study was conducted at the KEM Hospital, which provides primary and referral services at low cost or free of charge to a diverse cross-section of patients from the city and surrounding region. Patients over 18 years of age without overt psychotic symptoms, who presented for treatment in the KEM Hospital casualty ward after alleged DSH were recruited for study. The designation of DSH was based on the account of the patient and either a relative or others who brought the patient to treatment. Patients were assessed with EMIC interviews for cultural epidemiological

study and with the Structured Clinical Interview for DSM-IV for Axis I disorders (SCID) for diagnostic assessment (First et al., 2001).

Instruments

EMIC interviews are instruments for assessing representations of designated health problems, in this case DSH, from the perspective of affected persons, their family or community (Weiss, 1997). The focus of EMIC interviews differs from instruments for psychiatric epidemiology, such as the SCID, which are primarily concerned with diagnosing psychiatric disorders. Versions of the EMIC and SCID had been previously developed and used in research at the KEM Hospital for cultural epidemiological study of leprosy and psychiatric disorders (Weiss et al,1992), and they have also been used in other psychiatric studies (Raguram et al.,2004; Raguram et al., 2001; Jadhav et al.,2001; Lee et al., 2001). Based on this experience, an EMIC interview (Parkar & Weiss, 1999) was developed for this study to assess patterns of distress (PD), perceived causes (PC), and prior help seeking (HS) with reference to both the DSH event and underlying problems. A pilot study of 60 patients guided revisions that produced the final version used in this study. Both EMIC and SCID interviews were administered in one of the two local languages of Mumbai, Marathi and Hindi; for a few patients, much of the interview was conducted in English.

Training research assistants

Researchers with clinical training and experience in psychiatry administered the EMIC and SCID interviews. Training included preliminary explanation of aims and objectives, and familiarity with the concepts and relevant literature. With

acquisition of pertinent skills for these interviews and assessments, a preliminary exercise in which they evaluated 10 cases from a routine clinical perspective, was followed by pilot interviews with the EMIC. Training for use of the SCID, an earlier version of which had been translated in a previous study at KEM Hospital (Weiss et al., 1991), made use of didactic video and printed training materials prepared by the developers of the SCID.

Data collection

Research interviews with the EMIC and SCID were typically administered over one to three several sessions, based on the endurance of the patients. The EMIC interview elicited both narrative accounts and categorical codes for interview items. Data noted categories reported concerning patterns of distress (PD), perceived causes (PC), triggers, and prior help seeking (HS). The research ethics committee of KEM Hospital approved the research protocol and associated instruments. After obtaining informed consent, researchers interviewed consenting participants with these instruments.

Analysis

The EMIC interview data set for cultural epidemiological study consists of coded variables for quantitative analysis and narrative qualitative data, coded for thematic content with reference to specific questions in the interview. Cultural epidemiological variables in the quantitative data set in key sections of the interview specified patterns of distress (PD), perceived causes (PC), and prior help seeking (HS). Trigger events precipitating DSH were post coded from narratives.

Data for quantitative analysis from SCID and EMIC interviews were entered in a computer with the Epi Info (version 6.04d) data entry module using a check file for logic and range checks. These data were imported into SAS for analysis. Frequencies of reported cultural epidemiological variables and the clinical epidemiological profile of psychiatric disorders were tabulated. Grouped categories based on shared meanings of precoded categories were also computed from responses to open-ended queries (designated spontaneous responses) and from categories identified in response to probe questions about categories not mentioned spontaneously. These EMIC interview data were tabulated for individual and grouped categories. Cultural epidemiological variables for PD, PC, triggers, and self help were each analyzed to specify the frequency of responses. Frequencies of psychiatric diagnoses associated with each category of response were tabulated with particular attention to unipolar (major and other) depression; substance use disorders, adjustment disorders, V-codes, and no diagnosis. Analysis identified cultural epidemiological variables associated with higher or lower rates of these disorders.

Qualitative data were managed and analyzed with MAXqda software. It facilitated qualitative analysis by providing access to coded text segments from selected records based on values of relevant variables in the data set. Importing variables from the quantitative data set in Epi Info and SAS made it possible to select records for analysis, and to examine thematically coded segments with reference to each question of the EMIC interview that elicits a narrative response. These qualitative data were used to identify socio-cultural themes from patients' narrative accounts in the EMIC interviews.

Results

Sample characteristics

Interviews were conducted over a six-month period from September 2000 to February 2001. The study sample consisted of 196 patients at least 18 years of age, 93 women and 103 men. The age and sex distribution is summarized in table 5.1. Women with DSH were relatively younger than men with DSH in a sample with a mean age of 26.4 years. Most patients were Hindu (88.3%), Marathi-speaking (70.9%), and had at least a high-school education (63.2%). Approximately half the sample had never been married (51.2%).

Table 5.1: Age and sex of patients studied after deliberate self-harm

Age	Men (n=103)		Women (n=93)		Total (196)	
	Mean (±sd): 28.3 (9.47)		Mean (±sd): 24.4 (7.25)		Mean (±sd): 26.4 (8.69)	
	Range: 18-55		Range: 18-56		Range: 18-56	
Range	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
18 – 24	48	46.6	60	64.5	108	55.1
25 – 30	21	20.4	18	19.4	39	19.9
31 – 36	19	18.5	10	10.8	29	14.8
37 – 42	4	3.9	3	3.2	7	3.6
43 – 48	3	2.9	0	0.0	3	1.5
49 – 54	7	6.8	1	1.1	8	4.1
55 – 60	1	1.0	1	1.1	2	1.0
All	103	100	93	100	196	100

Diagnostic profile

DSM-IV psychiatric diagnoses, based on SCID interviews, are summarised in table 5.2. Patients identified with V-codes, no diagnosis and adjustment disorders (with no other Axis-I disorder) accounted for 44.4% of patients studied. Among the

rest, 17 patients with other axis I disorders had dual diagnoses. Depressive disorders were most frequent (43.9%), with unipolar depressive disorder predominating (38.8). Among the 16.8% with disorders of substance use, most were alcohol dependant. Although patients with overt psychotic symptoms were excluded from the study, 3 patients were found to have psychotic disorders when assessed with the SCID interview.

Table 5.2: Diagnosis of patients after deliberate self-harm

Diagnosis[1]	Total (n=196)	
	Number	Percent
Unipolar major depression	76	38.8
Other depression	10	5.1
substance abuse and dependence	33	16.8
Psychosis[2]	3	1.5
Panic disorder	2	1.0
Pathological gambling	1	0.5
Somatoform pain	1	0.5
Adjustment disorder	45	23.0
V-code[3]	22	11.2
No diagnosis	20	10.2
Total[4]	213	108.7

[1]DSM-IV Axis I diagnosis based on SCID-IV interview.
[2]Psychosis includes paranoid schizophrenia and brief psychotic disorder
[3]V-codes are used in DSM-IV for relationship problems, academic problems, and additional conditions that may be a focus of clinical attention.
[4]The total number of diagnoses is greater than the number of subjects because of a dual diagnosis for some patients. Categories of adjustment disorders, V-code, and no diagnosis were exclusive of all other diagnoses

Socio-cultural contexts of DSH

Assessment of psychiatric disorders provides useful information about clinical contexts of suicidal behaviour. Other dimensions, however, also require consideration. Case studies from the illness narratives elicited in the EMIC interviews identified several characteristic thematic contexts. These included mental turmoil and a range of socially and culturally distinctive family problems, typically involving spouses, in-laws, and parent-child conflicts. Unfulfilled expectations at work or from frustration and failure in school played an important role. Alcohol and substance abuse took a toll not only on the person abusing the drug, but also on their wives. Chronic illness and serious disease were another important focus of many patients' problems. Some patients indicated they did not know about and did not want to consider help that might be available from health and community support services. The following case vignettes illustrate the power of these issues and contexts of suicidal behaviour.

Mental turmoil and family life

An 18-year-old woman was disturbed by the chaos of her family life, and identified this context as the source of much of her distress. She reported,

> Mine is a chaotic family. Nobody understands anyone else at home. We always keep on fighting with each other. Instead of taking care of us, my mother always shouts at us, even though I am not keeping well now. She doesn't bother about me. One of my friends takes me to a doctor for treatment, but my mother scolds me for that also. I am fed up now with all of this. There are also financial problems at home. On top

> of that, we keep on fighting with each other; shouting and abusing. That is the order of the day. I feel very lonely.

In-laws and mental illness

Problems with in-laws were frequently an important factor contributing to DSH. Such problems also interacted with a range of other personal, health-related, and social contexts. One patient, a middle-aged woman with a history of schizophrenia treated at KEM Hospital, recognized both her psychiatric and her family problems. She also explained their relative priority. After she was evicted from her in-laws' home and sent to her brother, who arranged for her treatment, she explained:

> My illness has affected my married life, but my in-laws are a bigger problem for me. They make my life miserable and no longer worth living. My husband tells me not to take tablets, because he feels I will not be able to bear a child; then my illness gets worse Although, my mental illness is a problem, I still feel my in-laws and their attitudes are more disturbing. I can take tablets for my illness, but what can I do to cope with these people?.

Family rejection of inter-caste marriage

A young woman suffered because her parents would not allow her to marry outside their caste, which she did anyway. But then she felt guilty about the pain she had caused her parents. When her mother developed a serious heart problem, this girl blamed herself. She feared this cultural conflict might bring on her mother's death.

> My parents refuse to accept my marriage. They don't even talk to me. Many people have inter-caste marriages, and ultimately they are accepted. But with me, nothing of that sort is happening. Now I have lost all hope. I also feel guilty for letting them down.

Unemployment

A 30 year-old man said his DSH was because he had not fulfilled his obligations towards his mother. He felt helpless and considered himself a burden on his family. As he described his situation, he compared himself to well-known stock characters of Hindi films—unemployed, shiftless, and socially disvalued. Identification with these popular Bollywood images added to the emotional burden of his unemployment. He began to take on the character of these characters:

> I have been out of work for 2 years. At this age, I am still a burden on my old mother, who still feeds me. I don’t like to eat without earning; I hate myself for this. I should be earning and feeding my mother but it is the other way around. I am 30 now, and there is hardly any time left for me to earn, even if I get a job. … I feel sorry for myself. Whenever I see movies like Saheb (Boss) and Kaamchor (Derelict), I think of myself as like those desperate heroes and feel sorry for myself.

School failure

A 19-year-old boy who failed his twelfth standard examination four times explained that he had tried to take his life because he felt he had let down his parents and friends. He explained that he no longer had any confidence in himself:

> This was my fourth failure. I was overwhelmed by sadness and hopelessness. Now I thought, “I'll never make it through!” I felt guilty for not living up to the expectations of my family and friends. Even as I was going to the centre to get my results, I was filled with nervousness. Will I ever be able to achieve success, at this rate? My mind was all confused—nothing was making any sense.

Marital problems with an abusive, suspicious, alcoholic husband

A young woman explained that her life was not worth living because of her difficult and complicated marriage. Her husband, an alcoholic, was unemployed and he beat her. She struggled to support her children, but ultimately as she felt she was losing control, she gave up:

> My husband is suspicious of me. He thinks I go around with other men. He refuses to believe me [when I deny that]. He abuses me physically and verbally. He hits me. When he gets angry, he tells me to leave the house and go away. You tell me, where can I go with five children? My husband is unemployed. There is hardly any money for us to eat. Somehow, I manage, but he doesn't understand. He keeps on demanding money, and when I refuse to give it to him, he beats me. Since the beginning of our marriage, I have faced these problems. Then my mother-in-law and husband both made life hell for me. I am telling you, doctor, a woman cannot live as she likes after marriage. Everything is finished. It is better to die, than live.

Alcohol ruining a man's life

Some patients abusing alcohol explained their problems as a result of various issues, often focussing on financial difficulties, alienation from their families who refused to support them, frequent interpersonal conflicts, and feelings of worthlessness as reasons they gave for drinking. Other patients, however, did acknowledge the adverse impact of alcohol on their lives, families, and finances:

> My alcohol problem has led to many problems in our life. My wife and mother are not willing to compromise. My financial problems are gradually increasing. Sometimes I feel that my family is ignoring me. My alcohol problem has turned me into a very different person.

Insurmountable aches and pains, and overwhelming responsibilities

Somatic symptoms, which resulted from either medical problems or somatoform disorders, were an identified cause of DSH for some patients. Somatic complaints typically included fatigue, weakness, and sleep problems. An unmarried 20 year-old woman suffering from joint pains felt helpless, pressured by work, and burdened by familial responsibilities.

> I have had body aches for so many years. Doctors said I have wind trouble (vatacha traas). Once I was admitted to the hospital for it. I am taking treatment. Three or four days ago, I had body aches. I was fed up with all this, really tired of it. So I took Tik-20 [brand of organo-phosphurus household insecticide], and then felt giddy. I have to work at home and take care of my brother and father. I have to force myself to work; and now I am just fed up with it.

Impact of disease (TB) on expectations

A young man suffering from tuberculosis described the social problems and mental turmoil resulting from his illness.

> Since March 1999, I have really begun to hate myself for this illness. I have TB, and because of it, in March 1999 I could not attend the railway interview; I also failed my final HSC examination for the second time. It makes me feel pathetic. I am a national level Kabbadi [indigenous Indian sport] champ, but with this illness, my weakness, and all these problems, I am almost physically handicapped. What is the point in carrying on? This illness has spread its dirty paws all over my life—my education, my job, and my future.

Too ashamed to seek help

A young married man tearfully explained that his DSH resulted from harassment by his wife, contradicting a cultural stereotype. Embarrassed to disclose that she had verbally and physically abused him, he questioned his own masculinity:

> Who can I go to for help for this problem? It is so embarrassing—a man being harassed by his wife! This is actually the first time that I am telling anyone about the details of this problem.

Cultural epidemiology with reference to psychiatric diagnosis

Categories for cultural epidemiological study were extracted from case studies and patients' narratives. To specify the distribution of relevant features of DSH, categories of the experience of the underlying problems (PD), perceived causes (PC) of the DSH event, immediate triggers precipitating the event, and prior help-

seeking efforts for the underlying problems were identified. The distribution of these categories of DSH-related experience, meaning, and behaviour, and their relationship to key psychiatric diagnoses are presented in this section.

Patterns of distress

Unlike our outpatient psychiatric clinic in Mumbai, where depressive symptoms are reported less frequently than somatic symptoms, fewer DSH patients reported somatic symptoms (51.0%). Nearly all patients (95.9%) reported depressive symptoms followed by miscellaneous (88.3%) and anxiety group symptoms (59.7%). The most frequently reported individual categories were sadness, helplessness, worthlessness, sleep disturbance, and guilt. Although depressive group symptoms were associated with depression (table 5.3), for a substantial portion of the sample, these core symptoms of depression were associated with no axis I diagnosis: 39.3% of patients reporting sadness, 37.4% for helplessness, and 33.8% for worthlessness. The lower rate of patients reporting "other" categories of distress with depression (29.4%) was suggestive, but not significant (p=0.11). These problems included self-directed anger, and frustration with social and situational stressors, such as school failure, infertility, feeling cheated, and so forth. Commonly reported somatic symptoms were associated with higher rates of major depression than core depressive symptoms.

Table 5.3: Distribution of diagnoses among patients reporting various categories of distress

Symptoms and categories of distress	Reporting category (n=196)		Percentage of patients reporting category with diagnosis					
	Number	Percent	Maj Depr	Other Depr	Subst Use	Adj Dis	V-Code	No Diag
Total Sample Reference	**196**	**100**	**38.8**	**5.1**	**16.8**	**23.0**	**11.2**	**10.2**
DEPRESSIVE	**188**	**95.9**	**40.4***	**5.3**	**16.5**	**23.9**	**10.6**	**9.6***
Sadness	163	83.2	46.6**	6.1	16.0	25.2	9.8	4.3**
Helplessness	147	75.0	50.3**	6.8	15.0	26.5*	9.5	1.4**
Worthlessness	133	67.9	51.9**	6.8	15.0	22.6	8.3	3.0**
Suffocation	10	5.1	90.0**	0.0	10.0	10.0	0.0	0.0
Guilt	120	61.2	38.3	5.0	17.5	24.2	12.5	13.3
SOMATIC	**100**	**51.0**	**56.0****	**8.0**	**16.0**	**22.0**	**5.0****	**2.0****
Fatigue	99	50.5	61.6**	7.1	18.2	15.2**	6.1*	3.0**
Physical Pain	72	36.7	63.9**	9.7*	13.9	16.7	2.8**	1.4**
Giddiness (Chakkar)	51	26.0	64.7**	11.8*	13.7	11.8*	2.0*	3.9
Burning	13	6.6	76.9**	7.7	15.4	7.7	0.0	0.0
Tingling	39	19.9	61.5**	15.4**	12.8	17.9	0.0*	0.0*
Other Somatic	63	32.1	61.9**	7.9	17.5	19.0	6.3	1.6**
Sleep Disturbance	130	66.3	55.4**	6.2	21.5*	25.4	1.5**	1.5**
PSYCHOSIS	**10**	**5.1**	**30.0**	**10.0**	**40.0***	**10.0**	**0.0**	**0.0**
ANXIETY	**117**	**59.7**	**56.4****	**7.7***	**13.7**	**22.2**	**9.4**	**1.7****
Anxiety	84	42.9	59.5**	7.1	15.5	22.6	8.3	1.2**
Suicidal ideation	84	42.9	61.9**	9.5*	10.7*	21.4	6.0*	1.2**
MISCELLANEOUS	**173**	**88.3**	**41.0**	**5.2**	**19.1***	**22.0**	**11.0**	**8.7***
Eating Disturbance	64	32.7	64.1**	10.9**	9.4	18.8	3.1*	3.1*
Impaired Memory	42	21.4	73.8**	9.5	9.5	14.3	0.0**	0.0*
Sensitive to Rejection	41	20.9	51.2	4.9	17.1	26.8	7.3	4.9
Interpersonal	68	34.7	47.1	5.9	17.6	20.6	11.8	2.9*
Disturbed Sense of Self	42	21.4	52.4*	7.1	26.2	26.2	11.9	0.0*
Social Isolation	21	10.7	61.9*	9.5	9.5	28.6	4.8	0.0
Stigma	13	6.6	53.8	23.1**	7.7	7.7	7.7	0.0
Hostility	81	41.3	39.5	8.6	17.3	19.8	9.9	9.9
Substance abuse	22	11.2	50.0	4.5	77.3**	13.6	0.0	0.0
Other	51	26.0	29.4	0.0	19.6	15.7	13.7	19.6*

Note: Categories of distress and diagnoses reported by more than 5% of respondents are listed.
*p<.05 and **p<.01 base on table scores computed with estimate of common relative risk.

Perceived causes

The most frequently reported perceived causes were under the group headings of social (89.3%) and psychological categories (84.7%) (table 5.4). The most frequently reported individual categories were mental turmoil (81.1%), financial

problems (41.3%), conflicts with in-laws (37.2%), and marital problems (20.9%). Grouped categories most frequently associated with major depression were injury and illness, fate, and prior deeds or karma. Chronic illness was the cause for which major depression was most frequent (80.0%). Others that were associated with high rates of major depression included fate, financial problems, and prior deeds. Each of these suggests a problem with which individuals feel they cannot cope, and for which no solution appears possible. Perceived causes that were most often associated with no Axis-I disorders included bereavement, personality problems, and problems with a spouse.

Table 5.4: Distribution of diagnoses among patients reporting various categories of perceived causes

Perceived causes	Reporting category (n=196)		Percentage of patients reporting category with diagnosis					
	Number	Percent	Maj Depr	Oth Depr	Subst Use	Adj Dis	V-Code	No Diag
Total Sample Reference	**196**	**100**	**38.8**	**5.1**	**16.8**	**23.0**	**11.2**	**10.2**
INGESTION	**43**	**21.9**	**41.9**	**2.3**	**65.1****	**18.6**	**0.0****	**2.3***
Alcohol	38	19.4	39.5	0.0	71.1**	18.4	0.0*	2.6
Prescribed Med	2	1.0	100	50.0**	0.0	0.0	0.0	0.0
MEDICAL-PHYSICAL	**25**	**12.8**	**68.0****	**16.0****	**20.0**	**8.0**	**0.0**	**0.0**
Prior or chronic Illness	15	7.7	80.0**	20.0**	13.3	0.0*	0.0	0.0
Weakness	11	5.6	54.5	9.1	27.3	9.1	0.0	0.0
SOCIAL	**175**	**89.3**	**40.0**	**5.7**	**17.7**	**24.6**	**9.7**	**9.7**
Failed Romance	21	10.7	42.9	0.0	19.0	38.1	9.5	0.0
Problem with Spouse	41	20.9	39.0	7.3	24.4	12.2	7.3	19.5*
Family-in Laws	73	37.2	38.4	8.2	19.2	26.0	8.2	4.1*
Work	34	17.3	50.0	5.9	41.2**	20.6	2.9	0.0*
Unemployment	37	18.9	45.9	2.7	13.5	32.4	8.1	2.7
Breakdown of Family	17	8.7	35.3	11.8	23.5	29.4	5.9	11.8
Other Interpers	41	20.9	31.7	2.4	22.0	22.0	22.0*	9.8
Bereavement	10	5.1	30.0	0.0	0.0	10.0	30.0	30.0*
Financial	81	41.3	58.0**	6.2	22.2	19.8	4.9*	4.9*
VICTIMISATION	**17**	**8.7**	**29.4**	**11.8**	**17.6**	**29.4**	**5.9**	**5.9**
Victim of Violence	14	7.1	28.6	7.1	21.4	28.6	7.1	7.1
MAGIC-SPIRITS	**23**	**11.7**	**43.5**	**17.4****	**8.7**	**21.7**	**0.0**	**13.0**
Sorcery	15	7.7	53.3	20.0**	13.3	20.0	0.0	6.7
Demons	11	5.6	18.2	18.2*	0.0	27.3	0.0	18.2
DEEDS-KARMA	**30**	**15.3**	**56.7***	**6.7**	**16.7**	**13.3**	**3.3**	**6.7**
Bad Deed Prev Life	18	9.2	55.6	11.1	16.7	16.7	5.6	0.0

Perceived causes	Reporting category (n=196)		Percentage of patients reporting category with diagnosis					
	Number	Percent	Maj Depr	Oth Depr	Subst Use	Adj Dis	V-Code	No Diag
Total Sample Reference	**196**	**100**	**38.8**	**5.1**	**16.8**	**23.0**	**11.2**	**10.2**
PSYCHOLOGICAL	**166**	**84.7**	**41.6**	**5.4**	**18.1**	**23.5**	**10.2**	**9.6**
Mental turmoil	159	81.1	43.4**	5.7	18.9	24.5	9.4	6.9**
Personality	33	16.8	18.2**	3.0	24.2	24.2	15.2	24.2**
FATE	**46**	**23.5**	**58.7****	**6.5**	**8.7**	**15.2**	**4.3**	**8.7**
Fate	46	23.5	58.7**	6.5	8.7	15.2	4.3	8.7
MISCELLANEOUS	**46**	**23.5**	**28.3**	**6.5**	**6.5***	**15.2**	**17.4**	**19.6***
Other	46	23.5	28.3	6.5	6.5*	15.2	17.4	19.6*

Note: Categories of perceived causes and diagnoses reported by more than 5% of respondents are listed. *p<.05 and **p<.01 from estimate of common relative risk for variable and probability estimate based on table scores.

Triggers

Interpersonal conflicts were clearly the most frequently reported group of triggers leading to DSH (67.9%) (table 5.5). Other groups of frequently reported triggers included unfulfilled expectations (39.8%) and victimisation (32.1%). Although mental turmoil was the most frequently reported perceived cause, mental health problems were infrequently reported triggers of the DSH event, as illustrated by the case vignette on in-laws and mental illness. Among the triggers associated with major depression, one’s own illness (81.3%), sadness (78.6%), and financial problems (62.5%) were reported most frequently. Living with someone who abuses drugs was also associated with major depression (69.2%). Triggers least often associated with enduring Axis-I disorders (which here does not include adjustment disorders) were related to interpersonal conflict, especially with siblings, parents, and spouse.

Table 5.5: Distribution of diagnoses for triggers of DSH

Triggers	Reporting category (n=196)		Percentage of patients reporting category with diagnosis					
	Number	Percent	Maj Depr	Oth Depr	Sub Use	Adj Dis	V-Code	No Diag
Total Sample Reference	**196**	**100**	**38.8**	**5.1**	**16.8**	**23.0**	**11.2**	**10.2**
PHYSICAL HEALTH	**23**	**11.7**	**60.9***	**8.7**	**4.3**	**13.0**	**13.0**	**4.3**
Own illness	16	8.2	81.3**	12.5	0.0	0.0 *	6.3	0.0
MENTAL HEALTH	**33**	**16.8**	**51.5**	**9.1**	**15.2**	**15.2**	**9.1**	**3.0**
Tension	10	5.1	50.0	10.0	30.0	10.0	10.0	0.0
Sadness	14	7.1	78.6**	14.3	14.3	7.1	0.0	0.0
Bereavement	5	2.6	20.0	0.0	0.0	20.0	40.0*	20.0
SUBSTANCE ABUSE	**46**	**23.5**	**45.7**	**2.2**	**60.9****	**13.0**	**2.2***	**4.3**
Substance abuse (another)	13	6.6	69.2*	0.0	7.7	15.4	0.0	7.7
Substance abuse (self)	31	15.8	38.7	3.2	87.1**	12.9	0.0*	3.2
EXPECTATIONS	**78**	**39.8**	**50.0****	**2.6**	**12.8**	**29.5**	**9.0**	**6.4**
Job or business (self)	41	20.9	43.9	2.4	14.6	43.9**	2.4*	2.4
Financial problem	32	16.3	62.5**	3.1	18.8	25.0	3.1	6.3
Other unfulfilled expectations	10	5.1	60.0	0.0	0.0	30.0	0.0	10.0
INTERPERS CONFLICT	**133**	**67.9**	**32.3****	**5.3**	**18.0**	**21.8**	**12.8**	**13.5**
With parent	42	21.4	31.0	0.0	19.0	19.0	21.4*	11.9
With in-laws	19	9.7	42.1	15.8*	5.3	31.6	5.3	5.3
With spouse	40	20.4	37.5	10.0	27.5*	12.5	5.0	17.5
With siblings	20	10.2	20.0	0.0	10.0	25.0	15.0	30.0**
Romantic problem	17	8.7	47.1	0.0	11.8	29.4	11.8	0.0
Other interpers problem	17	8.7	29.4	5.9	11.8	29.4	17.6	5.9
VICTIMISATION	**63**	**32.1**	**42.9**	**6.3**	**9.5**	**20.6**	**9.5**	**14.3**
Other physical abuse	21	10.7	47.6	14.3*	4.8	9.5	14.3	9.5
Verbal abuse	26	13.3	42.3	3.8	11.5	19.2	15.4	15.4
Other victimisation	14	7.1	42.9	14.3	0.0	21.4	7.1	14.3

Note: Categories of triggers and diagnoses reported by more than 5% of respondents are listed.
*p<.05 and **p<.01 from estimate of common relative risk for variable and probability estimate based on table scores.

Help seeking and self-help

The vast majority of patients (81.6%) had not previously sought any professional or other help outside their home, apart from the assistance of friends or family. Among the rest who had sought external help, most consulted a private general practitioner (5.1%) or a psychiatrist (4.6%). Fewer had consulted other sources of help, including government hospital clinics and uncredentialed doctors

(3.6% each); Ayurvedic practitioners and healing temples (2.0% each); astrologers, faith healers, and local herbal healers (1.5% each), and homeopaths and religious leaders (1.0% each). Because so few patients had consulted health care providers, we did not analyze the relationship between prior help seeking experience and psychiatric diagnosis.

Table 5.6:Distribution of diagnoses for categories of self help before DSH

Self Help Categories	Reporting category (n=196)		Percentage of patients reporting category with diagnosis					
	Number	Percent	Maj Depr	Oth Depr	Sub Use	Adj Dis	V-Code	No Diag
Total Sample Reference	**196**	**100**	**38.8**	**5.1**	**16.8**	**23.0**	**11.2**	**10.2**
Change lifestyle	23	11.7	52.2	4.3	43.5**	17.4	13.0	4.3
Talk with close family	31	15.8	41.9	6.5	12.9	19.4	9.7	9.7
Talk with friends	37	18.9	59.5**	10.8	16.2	16.2	5.4	8.1
Prayer, temple, or fast	21	10.7	57.1	4.8	14.3	19.0	0.0	9.5
Other problem-solving	70	35.7	52.9**	5.7	15.7	21.4	11.4	2.9**
None	74	37.8	23.0**	4.1	13.5	24.3	10.8	23.0**

Note: Categories of triggers and diagnoses reported by more than 5% of respondents are listed.
*p<.05 and **p<.01 from estimate of common relative risk for variable and probability estimate based on table scores.

The most frequently reported category of self-help was “none” (37.8%), followed by problem-specific problem-solving efforts (35.7%), such as job hunting; trying to improve performance in school, college, or work; or trying harder to get along with others (table 5.6). No one reported use of the suicide prevention telephone hotline services that are available in Mumbai. Patients who sought help from friends and colleagues, or from prayer or visiting a temple were more likely to fulfil criteria for major depression. The patients with substance use disorders most typically reported they had tried to change their lifestyle. A diagnosis of major depression was particularly likely to motivate some kind of self-help seeking and less likely to be associated with no help seeking. Such patients who reported doing

nothing were most likely to be identified with no diagnosis from diagnostic assessment with the SCID.

Discussion

Efforts to explain to explain suicide in practical terms that inform clinical and population-based policy and interventions typically focus on the role of high-risk psychiatric disorders. This study examined the diagnostic profile of patients admitted for DSH, and it examined the socio-cultural contexts of underlying problems, perceived causes, and triggers of patients' suicidal behaviour. Using methods of cultural epidemiology, we have analyzed the relationship between the most frequent psychiatric disorders and local DSH-related experience, meaning, and behaviour. Both assessments provide important complementary contributions to the prevention of suicidal behaviour and management of DSH.

Our findings confirm the relevance of psychiatric disorders, especially depression, which was the most frequent diagnosis in our sample, and substance use disorders. Our findings, however, also show that focussing exclusively on diagnosis fails to explain the contexts of risk and vulnerability that motivate suicidal behaviour for a substantial portion of our patients. A substantial subset (44.4%) either do not meet criteria for an enduring Axis-I disorder (apart from adjustment disorders), or they qualify either for no diagnosis or a V-code. Other considerations clearly require attention for these patients and for comparable persons who do not meet criteria for a psychiatric disorder but are at risk for suicidal behaviour in the general population. Psychiatric disorders and socio-cultural stressors interact, as illustrated by our case report of a woman acknowledging the role of both her mental

illness (schizophrenia) and harassment from her in-laws, and by our other case reports.

Among findings from relating cultural and psychiatric epidemiological data, the somatic focus of depression was notable. Compared to the rate of major depression in the overall sample (38.8%), rates of depression were particularly high for the group of patients reporting somatic patterns of distress (56.0%), for one's own disease as a trigger of DSH (81.3%), and for prior illness as a perceived cause (80.0%). Other factors, however, operated independently of an association with depression. For the group of patients who identified bereavement as a PC for DSH, rates were lower than the overall sample for major depression (30.0%) and substance use disorders (0.0%). Uncomplicated bereavement is the only situational stressor that specifically excludes a diagnosis of major depression.

Substance use disorders as risk factors for suicidal behaviour have been widely acknowledged (Marttunen et al., 1991; Beck and Steer, 1989; Harris and Barraclough, 1997). We also found that the impact of such disorders in our sample affected not only the substance abuser, but also others in his family, particularly his wife, as reported by 6.6% of patients. Such patients were more likely to fulfil criteria for major depression (69.2%) than the overall sample.

Our findings suggest the need for critical reflection on the emphasis in much of the literature of suicidology on the role of high-risk psychiatric disorders to ascertain the value and limitations of this approach. The U.S. Surgeon General's report argues suicide rates indicate the need of mental health care (DHHS, 2001). That may be so, but community mental health problems may benefit from considerations beyond the criteria of psychiatric disorders, and this is a point that merits attention especially in the context of disadvantaged communities with poor

infrastructures and limited healthcare resources (Parkar et al., 2003). The emphasis on identifying and treating depression to prevent suicide has led to expectations that more prescriptions of psychotropics should reduce suicide rates in the population—a premise that remains controversial (Mann and Hendin, 2001), not just for the general population but also for psychiatric patients (Schou, 1988; Black et al.,1989).

Cross cultural differences in the focus on diagnosis and social stressors

A recent monograph published by the U.S. Institute of Medicine acknowledges that the emphasis on psychiatric diagnostic risk factors in North America and Western Europe may not be valid globally. Although the authors attribute 90% of suicides to mental disorders in the United States (Goldsmith, 2002, p.69), they note that socio-cultural stressors have been emphasized by investigators in various countries of Asia. In China, for example, higher rates of suicide than the United States appear to coexist with lower rates of mental illness (Shen et al., 1992). Government of India statistics identify mental illness (4.9%) and drug abuse or addiction (1.0%) as less frequent causes of suicide than we might expect (Government of India, 1999). Studies of suicide in India have found rates of depression similar to our findings for DSH. Gururaj and Isaac (2001) retrospectively diagnosed major depression in 43.3% of the 30 cases they studied, and no other psychiatric disorders. The causes they described were social and situational, similar to our findings: financial loss, family conflicts, illicit relationships of a spouse, illness of self or spouse, and frustrated teenage romance.

Consistent with other cross-cultural studies, this focus on social pain may be explained by cultural values and the priority of social interactions. It may be contrasted with the Western focus on individual determinants, based on

psychopathology, or the broader psychological formulation suggested by Shneidman (1996) that identifies psych-ache as a key determinant of suicide. As our findings suggest, however, this distinction between individual and social is relative, rather than absolute. Each represents a different facet of suffering, and collectively they integrate various relevant features of suicidal behaviour that require the attention of mental health professionals in a bio-psycho-social formulation (Goldsmith et al., 2003).

As a practical matter, the absence of prior medical help seeking for DSH-related problems in this sample was striking. Unlike many European and Western studies, which show that a recent visit to a doctor often precedes suicidal behaviour, fewer than 1 in 5 patients of our sample had consulted a doctor for their identified problem. Although further study of recent clinical consultations for other health problems prior to DSH is warranted, it appears that clinical consultations do not precede DSH for our sample as frequently as they do in Western Europe and North America. This raises questions about cross-cultural limitations in the potential role of general practitioners for preventing suicidal behaviour beyond those already acknowledged (Morriss, 2002). Limited use of the health system for problems patients identified with DSH probably reflected the fact that patients did not regard these as health problems. Many said they had not done anything in particular to help themselves, among the various options for self-help that were reported, problem-solving strategies were identified most frequently. In view of the focus on somatic symptoms, however, our findings also indicate the importance of recognizing and addressing the psychosocial contexts of somatization and their potentially life-threatening consequences.

Conclusion

Our study has demonstrated the value of complementary psychiatric and cultural epidemiological assessments of suicidal behaviour. Locally relevant features, attentive to the impact on suicidal behaviour of psychopathology and sociocultural contexts and stressors should inform suicide prevention and community mental health interventions, and clinical practice.

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Chapter 6

Gender and the cultural context of deliberate self harm in a hospital clinic in Mumbai, India

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GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

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Gender and the cultural context of deliberate self harm in a hospital clinic in Mumbai, India

Abstract

The sex-based differences in reported suicide rates (higher for men than women in all countries except China) and rates of DSH (typically higher for women than men) are widely recognised. The particular ways in which socially constructed gender differences account for these differences, however, have not been adequately studied. The aim of research reported in this chapter was to identify the gender-specific features of DSH and to consider their practical significance. A study of 196 consecutive admissions (103 men and 93 women) for DSH to the emergency ward at the KEM Hospital, Mumbai, included assessment with an appropriately adapted EMIC interview and clinical diagnostic interview (SCID). Trigger events for DSH and the patterns of distress, perceived causes and prior help seeking for underlying problems were analysed with respect to sex differences to elaborate the gender basis of DSH. There was no significant difference in percentage of Axis I psychiatric disorders including unipolar major depression for women and for men, mainly on account of high rates of substance use disorders in men (33.3%) compared with women (1.9%). Job and employment-related issues also figured more prominently as triggers of DSH among men. For women, victimisation generally and especially through verbal abuse was more frequent. Among the perceived causes, family problems—mainly with in-laws and spouse—were frequently reported by women. More men identified difficulties fulfilling their financial obligations to support their family as reasons for DSH. The narrative accounts highlight the nature of these issues and clarify their practical implications. Some of these narratives also highlight the gender-specific meaning of triggers, underlying patterns of distress and

perceived causes even though the frequency of reported categories may be similar. Appreciation of the role of gender-related features of DSH enhances the quality of empathic clinical care, and consideration of the role of gender indicated by these findings suggests particular community strategies through women's groups and men's organizations as agencies to promote use of relevant clinical services. Findings should also help community-based programmes implement social solutions and supports for social problems that may result in DSH and suicide.

Introduction

Epidemiological studies indicate that the rates of suicide among males are three times the rates of suicide among females in Europe and North America (Cantor, 2000; Cavan, 1928; Lester, 1998). However, in Asian countries including China, India and Japan, suicide mortality is highest in women between the ages of 15-24 (Cheng and Lee, 2000; Canetto & Lester; 1995; WHO, 1999). Although fewer completed suicides among women are reported in Western countries, a female preponderance is evident in the reporting of nonfatal deliberate self-harm (DSH) (Weissman, 1974; Hawton et al., 1994; Kreitman et al., 1977; Sakinofsky et al.,1990). Community studies from North America and Europe report higher rates of suicidal ideation and suicidal behaviour among females than males (Angst et al.,1992; Bronisch and Wittchen, 1994; Mosciki et al., 1988; Ramsay and Bagley, 1985).

Studies on suicide and gender have offered diverse theoretical explanations to explain the gender gap in suicidal behaviours (Canetto and Sakinofsky I,1998; Canetto, 1992). However, these explanations are commonly based on stereotyped assumptions of gender roles such as women being passive, suggestible and conforming (Canetto, 1992), traditional and adhering to religious restrictions against suicide (Davis,1904), and passively accepting the blows of life (Durkheim,1897 / 1951). Other studies have challenged the credibility of the female preponderance of DSH, citing underreporting of male DSH that result from cultural attitudes about masculinity and suicide. Mosciki (1994) explained that the discrepancy in male-female suicide rates is demonstrated by men’s and women’s differential gender-roles. These socioculturally determined gender roles may influence reporting of suicidal behaviours and the actual rates of completed suicides, as indicated by

women's use of less lethal methods that improve their chances of survival, better reporting of women's health histories, higher female treatment rates for depression, and lower rates of female alcoholism. In addition, factors, such as marriage may predispose women to suicidal behaviour, but protect men from it.

Current epidemiological studies do not focus on the cultural basis of suicidal behaviours including gender roles, ethnicity, and social class, but rather are focussed on demographic and clinical variables, are often retrospective in nature, and have not attempted to explain the differing ratios and patterns of suicide over time (Philips et al., 2002; Phillips and Ruth,1993). It is, however, possible that the circumstances and social events related to suicidal behaviour may truly differ for men and women. Canetto and Sakinofsky (1998) emphasized the important role of cultural influences in determining the gender gap in suicidal behaviour especially in communities where different suicidal behaviours are expected of females and males. Suicidal behaviour is modulated by its cultural context, which, depending on a variety of gender-specific and setting-specific factors, may encourage sympathy for the afflicted or perpetuate stigma of DSH and suicide.

Employing a cultural epidemiological approach to the study of DSH and suicide is particularly useful to capture the cultural determinants of these behaviours and their distribution, providing an analysis of the complementary relationship between immediate suicidal behaviours, patterns of distress, and perceived causes of the underlying problems. This research study intended to understand gendered responses to DSH events and how these events and circumstances are experienced and expressed culturally.

Aims and objectives

This study assessed gender in the context of a broader cultural epidemiological study of DSH. It is part of a study that was developed with the objective of expanding ongoing suicide intervention programmes for DSH patients referred for psychiatric evaluation in the department of psychiatry at KEM Hospital, in Mumbai, India. The study principally examined the gender-specific cultural context of patients' narrative accounts of their DSH event. These narratives reflected patients' DSH-related experience investigated as patterns of distress (PD), its meaning as perceived causes (PC), and associated behaviours as help seeking (HS), and those underlying problems of the event. The research also examined the relationship between clinical psychiatric diagnostic assessments with a focus on gender. We also focused on comparative gender aspects in terms of differences in the distribution of diagnostic profiles, and trigger events that are immediately associated with DSH. Our clinical interest was to identify the social and cultural context of DSH in an urban environment and to examine variations in its patterning.

Methods

This study was conducted at the KEM Hospital, a tertiary care centre of the Mumbai Municipal Corporation, which is located in an area populated mainly by lower middle class inhabitants. As a well-known municipal hospital, it provides a wide range of services to people at low or no cost. KEM Hospital attracts a diverse cross-section of patients from the city, and from other regions of India. KEM Hospital provides 24 hour emergency medical and surgical services.

Patients over 18 years of age who sought care at KEM after an alleged DSH event by self-poisoning were requested to participate in the study. The ethics

committee of KEM Hospital approved the research protocol and associated instruments. After obtaining informed consent, the study was conducted with an EMIC interview used for the cultural epidemiological component (Weiss, 2001;1997) and structural clinical instruments for assessment of DSM-IV (SCID-IV) for Axis-I psychiatric diagnoses(First et al.,2001).

Semi-structured EMIC interviews have been adapted for previous study at the KEM Hospital for cultural epidemiological research on leprosy, and elsewhere for cultural epidemiological research on mental disorders such as depression and schizophrenia (Weiss et al., 1992; Raguram et al.; 2001).These previous versions were adapted for the current study to focus on both the DSH event and the underlying problems associated with it.

Inasmuch as DSH is not itself a clinical disorder, and because we were interested in both the DSH event as well as underlying socio-cultural problems, emotional distress, and associated clinical disorders, the structure of this version of the EMIC was necessarily more complex than previous versions used for studying clinical disorders. The adaptation examined the complex relationship between the event and its antecedents. We found that a focus on events such as unemployment or school failure were not by themselves sufficiently informative, but required elaboration of how they were related to specific life circumstances and the stress that ultimately led to DSH. The final version of the EMIC used for this study went through three adaptations altogether, including translation to the local language, and alterations made following a pilot study conducted with 60 patients. In terms of gender sensitivity, special precautions were taken to understand emotional vulnerabilities disclosed by patients, especially women.

Research assistants were qualified psychiatrists and experienced in clinical training and psychiatry. As a preliminary exercise to introduce them to the project, the research assistants were explained the objectives of study and were asked to evaluate cases from a routine clinical perspective with special focus on listening to patients personal experience of DSH and underlying problems and documenting this experience. The issues related to gender and cultural context were considered carefully to identify and correct for any preconceptions by the research assistants concerning gender stereotypes that may have influenced interviewing.

Research interviews were typically broken in to several sessions, based on the attention and endurance of the patients. A detailed account of the methods is discussed elsewhere (see also chapter 5).

In their narrative accounts, patients frequently reported social and personal experiences that directly lead to DSH event. To understand the nature and priority of these circumstances, we used the grounded theory approach (Glaser and Strauss, 1967) and identified 34 categories of triggers. These categories were further grouped into six broad categories based on how they were related. These trigger events were then further classified into two types of responses based on how they were reported and those identified by the respondent as most important.

Analysis of EMIC data

The EMIC data set included both coded variables for quantitative analysis and spontaneous narrative accounts of the DSH event and associated problems for qualitative analysis. Frequencies of the variables for patterns of distress (PD), perceived causes (PC), and prior help-seeking behaviour (HS) were summarized in Epi Info version(6.04d), and were disaggregated by sex. Qualitative data were

managed and analysed with MAXqda software to facilitate analysis of coded segments from selected records.

Results

Sample characteristics

A total of 196 patients (103 males and 93 females) who visited the emergency medical service department of KEM Hospital for an alleged history of DSH with self-poisoning were recruited into the study and interviewed with an EMIC. Patients in the study ranged in age from 18-56 years for females, with a mean age of 24.4, and 18-55 years for males, with a mean age of 28.3. A majority of the patients spoke Marathi (the local language in Mumbai) followed by Hindi, and other regional languages. Most of the patients reported that they were Hindu, as per the population characteristic of area. Almost equal proportions of males and females were married and unmarried. Additional sample characteristics are summarised in Table 6.1.

Table 6.1 Sample characteristics of patients with DSH by sex

Sociodemographics	Female (n=93)	Male (n=103)
Age		
Mean age	24.4	28.3
Age range	18-56	18-55
Mother tongue (%)		
Marathi	76.3	68.9
Hindi	11.8	14.5
Gujarati	5.5	7.8
South Indian	3.2	5.8
Other	1.1	0.0
Religion (%)		
Hindu	92.54	85.5
Muslim	5.5	7.8
Christian	2.1	5.0

Sociodemographics	Female (n=93)	Male (n=103)
Other	0.0	2.0
Marriage (%)		
Never married	49.5	52.6
Married	45.1	40.8
Separated and divorced	5.5	5.0
Remarried	0.0	1.0
Widowed	0.0	1.0
Education (%)		
None	9.0	4.6
Primary	14.0	7.2
Secondary	12.4	63.2
HSC	20.0	10.2
Degree	22.0	11.2
Professional	7.0	3.6
Occupation (%)		
Professional	6.4	15.6
Skilled	7.4	14.6
Unskilled	20.4	39.7
Housewives	32.2	0.0
Student	10.7	3.9
Unemployment	19.3	21.4
Others	4.3	3.9

Diagnostic profile

Diagnostic evaluations of patients with the SCID–IV indicated(refer table 6.2) that depressive disorders represent a major clinical problem for DSH patients. Male and female DSH patients suffered similarly from Uni-polar major depression (39.8% of males, 35.9% of females). Substance abuse and dependence disorders (typically alcohol dependence) affected significantly more males (33.3%) than females. Assessment of adjustment disorders, V-code diagnoses, and ‘no diagnosis’ was nearly equal among males (46.3%) and females (43.8%).

Table 6.2 : Diagnosis of patients after deliberate self-harm

Diagnosis[1]	Male (n=93)	Female (n=103)	Total (n=196)
	Percent	Percent	Percent
Unipolar major depression	39.8	37.9	38.8
Other depression	4.3	5.8	5.1
substance abuse and dependence*	33.3	1.9	16.8 *
Psychosis[2]	2.2	1.0	1.5
Panic disorder	1.1	1.0	1.0
Pathological gambling	1.1	0.0	0.5
Somatoform pain	0.0	1.0	0.5
Adjustment disorder	25.8	20.4	23.0
V-code[3]	10.8	11.7	11.2
No diagnosis	9.7	11.7	10.2

*p<.001, Fisher's exact test.
[1]DSM-IV Axis I diagnosis based on SCID-IV interview.
[2]Psychosis includes paranoid schizophrenia and brief psychotic disorder
[3]V-codes are used in DSM-IV for relationship problems, academic problems, and additional conditions that may be a focus of clinical attention.
[4]The total number of diagnoses is is greater than the number of subjects because of a dual diagnosis for some patients. Categories of adjustment disorders, V-code, and no diagnosis were exclusive of all other diagnoses except alcohol dependence in remission.

Triggers of DSH

Significant male-female differences were noted in two of the grouped categories of triggers(table 6.3). Behavioural triggers were more frequently reported among male patients (p<0.01), and victimisation as a trigger was more frequent among female patients (p<0.05). Although not significant, the gender specific trends were suggestive in other grouped categories. Somewhat more men than women reported the groups of triggers that were classified as ‘unfulfilled expectations’ and mental health problems (tension and sadness). Conversely, somewhat more women than men reported interpersonal problems as triggers for their DSH event.

There were many significant differences between men’s and women’s reporting of individual trigger categories. Substance abuse, job problems and unemployment, and financial problems were more commonly reported by men, and women more frequently identified interpersonal conflicts with in-laws, and both verbal

and substance abuse by male relatives as individual triggers. Among men, substance abuse and job and employment problems were reported as the most important triggers significantly more often than among women.

Table 6.3: Reported and Most Important Triggers for DSH by Sex (%)

Items and Clusters	Females (n=93)		Males (n=103)		Total (n=196)	
	Reported	Most Imp	Reported	Most Imp	Reported	Most Imp
Physical health problem	12.9	2.2	10.7	1.9	11.7	2.0
Disease (self)	8.6	2.2	7.8	1.9	8.2	2.0
Injury (self)	2.2	0.0	0.0	0.0	1.0 *	0.0
Other physical (self - other)	3.2	0.0	2.9	0.0	3.1	0.0
Mental health problem	**12.9**	**8.6**	**20.4**	**12.6**	**16.8**	**10.7**
Tension	2.2	2.2	7.8	2.9	5.1	2.6
Sadness	4.3	2.2	9.7	6.8	7.1	4.6
Hearing voices	2.2	1.1	1.0	1.0	1.5	1.0
Chronic mental illness	1.1	0.0	1.0	0.0	1.0	0.0
Bereavement	3.2	2.2	1.9	1.9	2.6	2.0
Other mental health	1.1	1.1	1.0	0.0	1.0	0.5
Behavioural problem	**12.9**	**0.0**	**33**	**11.7**	**23.5** **	**6.12**
Substance abuse (another)	10.8	0.0	2.9	0.0	6.6 *	0.0
Substance abuse (self)	2.2	0.0	28.2	10.7	15.8 **	5.6 **
Other behavioural	0.0	0.0	2.9	1.0	1.5	0.5
Unfulfilled expectations	**23.7**	**7.5**	**54.4**	**15.5**	**39.8**	**11.7**
School	3.2	1.1	3.9	1.0	3.6	1.0
Job-unemployment (self)	6.5	1.1	34	7.8	20.9 **	4.6 *
Job-unemployment (other)	4.3	0.0	1.9	1.0	3.1	0.5
Infertility	2.2	0.0	0.0	0.0	1.0	0.0
Financial problem	10.8	4.3	21.4	3.9	16.3 *	4.1
Poverty	2.2	0.0	1.9	0.0	2.0	0.0
Other expectations	3.2	1.1	6.8	1.9	5.1	1.5
Interpersonal conflict	**78.5**	**33.3**	**58.3**	**26.2**	**67.9**	**29.6**
With parent	18.3	11.8	24.3	13.6	21.4	12.8
With child	3.2	2.2	3.9	1	3.6	1.5
With in-laws	17.2	3.2	2.9	0.0	9.7 **	1.5
With spouse	24.7	5.4	16.5	5.8	20.4	5.6
With siblings	11.8	4.3	8.7	1.0	10.2	2.6
With other family members	2.2	1.1	1.0	0.0	1.5	0.5
Romantic problem	10.8	2.2	6.8	2.9	8.7	2.6
With other relatives	4.3	1.1	1.9	0.0	3.1	0.0
Other interpersonal problem	9.7	3.2	7.8	1.9	8.7	2.6
Victimization	**41.9**	**30.1**	**23.3**	**16.5**	**32.1** *	**23.0**
Sexual abuse	1.1	0.0	0.0	0.0	0.5	0.0
Other physical abuse	15.1	9.7	6.8	4.9	10.7	7.1
Verbal abuse	19.4	12.9	7.8	4.9	13.3 *	8.7
Threat	4.3	4.3	4.9	3.9	4.6	4.1
Caste or communal conflict	2.2	0.0	0.0	0.0	1.0	0.0
Other victimization	8.6	3.2	5.8	2.9	7.1	3.1
Cannot say	**0.0**	**18.3**	**0.0**	**15.5**	**0.0**	**16.8**

Note: Multiple responses permitted for reported triggers, but one only for most important trigger.For most important trigger, 33 patients could not identify a single most important category. They were coded as "cannot say".
*p<0.05, **p<0.01, Fisher's exact test.

Patients often indicated that the triggers associated with the DSH event were a combination of personal, familial, and community problems. These triggers were commonly understood to be the cause of the underlying problem they were suffering from. Both male and female patients reported triggers that reflected their inability to assume their expected gender roles.

Common themes among male respondents dealt with issues surrounding unemployment and their inability to fulfil their gender-specific role as the family breadwinner; these men's inability to provide for their families frequently resulted in feelings of guilt. One such man reported,

> I don't want [my wife] to think that her husband is not earning and is incapable of taking care of her. If that was not enough, my father has started drinking alcohol again. I can't even rely on him now. I have been trying to find a job since 5 months, but since last 2-3 months, I have become desperate. I feel very guilty.

For some women, infertility and the subsequent community ridicule associated with this apparent failure to achieve an expected gender role resulted in a DSH event. One woman reported,

> The question of me not being able to conceive a child is my biggest enduring problem. That day, all those neighbours who were washing clothes with me began discussing my problem and passing sarcastic comments. I got fed up, went back home and after thinking for 3-4 hours, finally I decided to end my life. It makes me feel insecure,

worthless and of no use. It has taken away my peace of mind. I want to be a mother, so many of my dreams are shattered!

Patterns of distress

Although significant differences between men and women for reported grouped categories of distress were limited only to somatic distress (p<.01), several individually reported categories indicated significant gender-specific differences (table 6.4). Substance abuse was reported significantly more often among males, whereas females reported hostility, interpersonal problems, sexual distress, and somatic symptoms significantly more than men did.

The majority of responses were elicited spontaneously, and only a few sensitive categories such as somatic symptoms and hostility among women, and sadness and helpless among men, required probing.

Table 6.4: Reported categories of distress by sex (%)

Items and Clusters	Women (n=93)		Men (n=103)		Total (n=196)	
	Spon	Probed	Spon	Probed	Spon	Probed
I. Depressive	**84.9**	**7.5**	**90.3**	**8.7**	**87.8**	**8.2**
Sadness	71.0	11.8	66.0	17.5	68.4	14.8
Helpless	67.7	5.4	64.1	12.6	65.8	9.2
Worthlessness	55.9	11.8	57.3	10.7	56.6	11.2
Suffocation	5.4	1.1	2.9	1.0	4.1	1.0
Guilt	41.9	12.9	55.3	11.7	49.0	12.2
II. Somatic	**40.9**	**16.1**	**26.2**	**19.4**	**33.2**	**17.9** *
Fatigue	37.6	17.2	31.1	15.5	34.2	16.3 *
Physical Pain	26.9	15.1	19.4	12.6	23.0	13.8
Giddiness (Chakkar)	16.1	20.4	3.9	12.6	9.7	16.3 **
Burning	5.4	5.4	1.9	1.0	3.6	3.1 *
Tingling	12.9	12.9	6.8	7.8	9.7	10.2 *
Wind-Vat	1.1	1.1	0.0	1.0	0.5	1.0
Other Somatic	34.4	4.3	21.4	4.9	27.6	4.6
Sleep Disturbance	48.4	10.8	60.2	12.6	54.6	11.7
III. Psychosis	**3.2**	**1.1**	**3.9**	**1.9**	**3.6**	**1.5**
Delusional	1.1	1.1	1.0	1.0	1.0	1.0
Hallucinations	3.2	0.0	1.9	1.9	2.6	1.0
Paranoid	2.2	1.1	2.9	1.9	2.6	1.5
IV. Anxiety	**51.6**	**6.5**	**49.5**	**11.7**	**50.5**	**9.2**
Anxiety	29.0	10.8	35.9	9.7	32.7	10.2
Fear	3.2	2.2	1.0	1.9	2.0	2.0

Items and Clusters	Women (n=93)		Men (n=103)		Total (n=196)	
	Spon	Probed	Spon	Probed	Spon	Probed
Panic	2.2	0.0	1.9	0.0	2.0	0.0
Self-Harm	43.0	3.2	35.0	4.9	38.8	4.1
V. Miscellaneous	**76.3**	**11.8**	**80.6**	**7.8**	**78.6**	**9.7**
Eating Disturbance	29.0	10.8	21.4	4.9	25.0	7.7
Impaired Memory	15.1	9.7	12.6	5.8	13.8	7.7
Rejection sensitive	22.6	2.2	14.6	2.9	18.4	2.6
Interpersonal	39.8	1.1	24.3	4.9	31.6	3.1 *
Sense of Self	12.9	5.4	20.4	3.9	16.8	4.6
Social Isolation	6.5	1.1	5.8	7.8	6.1	4.6
Stigma	5.4	0.0	6.8	1.0	6.1	0.5
Hostility	33.3	18.3	19.4	12.6	26.0	15.3 *
Substance abuse	0.0	0.0	19.4	1.9	10.2	1.0 **
Sexual	3.2	4.3	0.0	1.0	1.5	2.6 *
No Overt Symptom	2.2	0.0	0.0	0.0	1.0	0.0
Other	24.7	1.1	24.3	1.9	24.5	1.5

*p<0.05, **p<0.01, Wilcoxon test.

Investigation of patients' single most important pattern of distress also revealed potentially interrelated gender-specific differences(table 6.5). Males more commonly reported depression, drug abuse, and alcohol dependence as the most important pattern of distress, whereas women more commonly identified hostility as the most distressing feature of their condition.

Table 6.5: Most important categories of Distress by sex (%)

Items and Clusters	Female (n=93)	Male (n=103)	Total (N=196)
I. Depressive	**59.1**	**66.0**	**62.8**
Sadness	15.1	19.4	17.3
Helpless	18.3	13.6	15.8
Worthlessness	11.8	14.6	13.3
Guilt	14.0	18.4	16.3
II. Somatic	**5.4**	**4.9**	**5.1**
Fatigue	1.1	1.0	1.0
Physical pain	1.1	1.0	1.0
Giddiness (*chakkar*)	1.1	0.0	0.5
Other somatic	1.1	0.0	0.5
Sleep disturbance	1.1	2.9	2.0
III. Psychosis	**1.1**	**1.0**	**1.0**
Hallucinations	1.1	1.0	1.0
IV. Anxiety	**1.1**	**0.0**	**0.5**
Anxiety	1.1	0.0	0.5
V. Miscellaneous	**33.3**	**28.2**	**30.6**
Impaired memory	0.0	1.0	0.5

Items and Clusters	Female (n=93)	Male (n=103)	Total (N=196)
Rejection sensitive	2.2	1.9	2.0
Interpersonal	5.4	2.9	4.1
Sense of self	1.1	1.0	1.0
Hostility	3.2	1.9	2.6
Substance abuse	0.0	5.8	3.1 *
No overt symptom	3.2	0.0	1.5
Other	17.2	12.6	14.8
Cannot say	1.1	1.0	1.0

*p<0.05, Fisher's exact test.

Among men who reported substance abuse as a pattern of distress, their narrative accounts reflected an combination of financial, social, and psychological issues related to their DSH event and it's underlying problems. Many of these men reported having faced rejection, criticism, and a lack of support and humiliation from their family members. One such alcoholic man reported,

> My family cannot tolerate my alcohol problem. It makes me feel worthless. Why does my family have to hate me and my alcohol problem? Nobody loves me here; they will never understand my problem.

Alcohol abuse among men often compounded existing familial tensions and hostilities as well as financial difficulties. One man reported,

> Family conflict and the problems between me, my mother and my wife are going over board. It is time everything comes to an end now. My alcohol problem has led to other problems in our life. My financial problems are gradually increasing. At times I really feel that my family is ignoring me.

Female patients did not report that they themselves had abused alcohol and other substances, but their narrative reports indicated that these dependence issues were problematic and distressing for them as well. For many women, husbands,

fathers, and other male family members abused alcohol, resulting in women's emotional distress, felt pressure to earn when their husbands could not, experiences of domestic violence, and social disgrace. One woman reported,

> My life has been full of sorrows ever since I've been able to realize what's been happening around me. The root cause is my father - who is a chronic alcoholic- he daily consumes alcohol, and then comes home at night and causes a big fight. He shouts loudly and abuses all of us, he hits all of us. It is very embarrassing. Quite often during the week, I see him fallen on any side of the road, and my friends bring it to my notice. It's most embarrassing! Each day, I work hard at the office and come home to rest but my father ruins all our peace of mind. I could not accept this any longer, so I decided to end my life.

Emotional distress due to problems related to their husbands were common among women, even when their husbands were not abusing alcohol. Financial anxieties resulting from a husband's unemployment were common, resulting in feelings of helplessness and domestic disputes. One woman reported,

> My husband is unemployed since 7-8 months. Since then I have been tense about our future. I remain tense as nothing good happens in my life. I have now given up on everything. I thought the only way to get out of all problems is to kill myself. When my husband was not willing to take up a new job, I got very angry and hurt. I kept on thinking about it and so next day when he went out, I consumed poison.

Perceived causes of underlying problems

The most frequently reported grouped categories of perceived causes of underlying problems were psychological and social (table 6.6). A significant gender difference was reflected for only the group of causes related to ingestion, mainly concerning alcohol, which was more frequently reported by men as a cause of the problem underlying the DSH event.

Several individual categories were reported significantly more often by male respondents than by female, including alcohol, smoking, work, unemployment, and financial causes. Significantly more female patients reported problems with their spouse or in-laws, having been a victim of violence, and demons. Though not significant, higher frequencies of failed romance, fate, and personality reported by women were suggestive.

Social causes were the most frequently reported grouped PCs but no significant gender differences were noted.

Table 6.6: Reported Perceived Causes by sex (%)

Items and Clusters	Female (n=93)		Male (n=103)		Total (n=196)		
	Spon	Probed	Spon	Probed	Spon	Probed	
INGESTION	**12.9**	**0.0**	**25.2**	**4.9**	**19.4**	**2.6**	**
Food/water	1.1	0.0	0.0	0.0	0.5	0.0	
Alcohol	10.8	0.0	23.3	3.9	17.3	2.0	**
Smoking	0.0	0.0	2.9	1.9	1.5	1.0	*
Drug	0.0	0.0	2.9	1.0	1.5	0.5	
Prescribed medication	1.1	0.0	1.0	0.0	1.0	0.0	
INJURY/MEDICAL	**7.5**	**2.2**	**14.6**	**1.0**	**11.2**	**1.5**	
Injury	0.0	0.0	2.9	0.0	1.5	0.0	
Overwork	1.1	1.1	0.0	0.0	0.5	0.5	
Prior illness	7.5	0.0	7.8	0.0	7.7	0.0	
Liver weakness	0.0	0.0	1.9	0.0	1.0	0.0	
Weakness	2.2	1.1	5.8	1.9	4.1	1.5	
Nerves	0.0	0.0	1.9	0.0	1.0	0.0	
SOCIAL	**88.2**	**1.1**	**86.4**	**2.9**	**87.2**	**2.0**	
Failed romance	11.8	1.1	6.8	1.9	9.2	1.5	
Problem with spouse	26.9	1.1	13.6	1.0	19.9	1.0	*
Family-in laws	45.2	2.2	24.3	3.9	30.2	3.1	**

Items and Clusters	Female (n=93)		Male (n=103)		Total (n=196)		
	Spon	Probed	Spon	Probed	Spon	Probed	
Family illness	0.0	0.0	1.0	0.0	0.5	0.0	
Work	6.5	0.0	24.3	2.9	15.8	1.5	**
Unemployment	6.5	1.1	28.2	1.0	17.9	1.0	**
Breakdown of family	8.6	1.1	6.8	1.0	7.7	1.0	
Other interpersonal	20.4	2.2	15.5	3.9	17.9	3.1	
Migration	0.0	0.0	0.0	1.0	0.0	0.5	
Bereavement	5.4	1.1	3.9	0.0	4.6	0.5	
Financial	25.8	4.3	44.7	6.8	35.7	5.6	**
ABUSE	**9.7**	**2.2**	**2.9**	**2.9**	**6.1**	**2.6**	
Childhood abuse	1.1	0.0	1.9	1.0	1.5	0.5	
Victim of violence	8.6	2.2	1.9	1.9	5.1	2.0	
Sexual abuse	1.1	0.0	0.0	0.0	0.5	0.0	
MAGIC/SPIRITS	**9.7**	**5.4**	**3.9**	**4.9**	**6.6**	**5.1**	
Sorcery	6.5	1.1	3.9	3.9	5.1	2.6	
Demons	6.5	4.3	0.0	1.0	3.1	2.6	**
Bad place (*vastu*)	2.2	0.0	0.0	0.0	1.0	0.0	
Other supernatural	5.4	0.0	1.0	0.0	3.1	0.0	
DEEDS/KARMA	**6.5**	**10.8**	**3.9**	**9.7**	**5.1**	**10.2**	
Poor health habits	1.1	1.1	1.0	1.0	1.0	1.0	
Bad deed	2.2	1.1	1.9	2.9	2.0	2.0	
Bad deed prev life	3.2	8.6	1.0	5.8	2.0	7.1	
PSYCHOLOGICAL	**81.7**	**1.1**	**82.5**	**3.9**	**82.1**	**2.6**	
Mind-worry	74.2	3.2	79.6	4.9	77.0	4.1	
Personality	16.1	5.4	9.7	2.9	12.8	4.1	
HEREDITY	**2.2**	**2.2**	**3.9**	**0.0**	**3.1**	**1.0**	
Upbringing	2.2	2.2	3.9	0.0	3.1	1.0	
SANITATION	**0.0**	**0.0**	**1.0**	**0.0**	**0.5**	**0.0**	
Contamination infection	0.0	0.0	1.0	0.0	0.5	0.0	
SEXUAL	**3.2**	**2.2**	**0.0**	**1.0**	**1.5**	**1.5**	
Premarital sex	0.0	0.0	0.0	1.0	0.0	0.5	
Adultery	2.2	0.0	0.0	0.0	1.0	0.0	
Semen loss	0.0	1.1	0.0	0.0	0.0	0.5	
Sexual weakness	1.1	0.0	0.0	0.0	0.5	0.0	
Menstrual problem	0.0	2.2	0.0	0.0	0.0	1.0	
HEAT-COLD, AYURVED	**1.1**	**0.0**	**0.0**	**0.0**	**0.5**	**0.0**	
Wind (*vayu*)	1.1	0.0	0.0	0.0	0.5	0.0	
FATE	**16.1**	**12.9**	**8.7**	**9.7**	**12.2**	**11.2**	
Fate	16.1	12.9	8.7	9.7	12.2	11.2	
MISCELLANEOUS	**26.9**	**1.1**	**17.5**	**1.9**	**21.9**	**1.5**	
Other	26.9	1.1	17.5	1.9	21.9	1.5	

*p<0.05, **p<0.01 Wilcoxon test.

Significantly more women than men reported problems with their spouse or in-laws as the most important individual PC, whereas more men reported unemployment and financial causes as the most important(table.6.7).

Table 6.7: Most important Perceived Causes by sex (%)

Items and clusters	Female (n=93)	Male (n=103)	Total (n=196)
INGESTION	**3.2**	**11.7**	**7.7** *
Food/water	1.1	0.0	0.5
Alcohol	2.2	9.7	6.1 *
Drug	0.0	1.0	0.5
Prescribed medication	0.0	1.0	0.5
INJURY/MEDICAL	**3.2**	**1.9**	**2.6**
Prior illness	3.2	1.9	2.6
SOCIAL	**60.2**	**58.3**	**59.2**
Failed romance	6.5	3.9	5.1
Problem with spouse	19.4	4.9	11.7 **
Family-in laws	20.4	6.8	13.3 **
Work	0.0	6.8	3.6
Unemployment	4.3	19.4	12.2 **
Breakdown of family	0.0	1.0	0.5
Other interpersonal	4.3	2.9	3.6
Bereavement	2.2	1.0	1.5
Financial	3.2	11.7	7.7 *
MAGIC/SPIRITS	**2.2**	**0.0**	**1.0**
Demons	2.2	0.0	1.0
PSYCHOLOGICAL	**9.7**	**4.9**	**7.1**
Mind-worry	2.2	1.0	1.5
Personality	7.5	3.9	5.6
FATE	**2.2**	**0.0**	**1.0**
Fate	2.2	0.0	1.0
MISCELLANEOUS	**12.9**	**12.6**	**12.8**
Other	12.9	12.6	12.8

*p<0.05, **p<0.01 Fisher's exact test.

Patients' narrative accounts clarified the complex relationship between the PCs of underlying problems and the DSH event in greater detail. For example, although unemployment as PC of the underlying problem was not directly linked to the DSH event, patients' narratives revealed that the social consequences of one's unemployment were. One man reported,

> My unemployment is my main problem. Because of this, I feel, I am a burden on my family, especially my younger brother.

Women's narratives also revealed concern about unemployment, particularly when it was compounded by pre-existing financial strains. One such woman reported,

> My unemployment had worsened our financial crisis. Such that, I cannot give my intelligent son the type of education he deserves- this hurts me most of all.

Interpersonal problems were especially salient causes of DSH among women. Married women often communicated problems with their in-laws and husbands. These types of problems are common to the joint family system in which married women are expected to be subservient and obedient to an often and stereotypically dominating mother-in-law. One such young woman reported,

> My mother-in-law is the main source of the tension I have been going through, since the last 10 years. She cannot stand both of us, me and my sister-in-law. Earlier she was good to my sister-in-law because she was working and would give her money. I was singled out at that time. But now she doesn't talk properly to both of us. In fact, she doesn't care for our children, it is as if they are not related to her. I would have moved out long back but my husband's income is not sufficient to rent a house for ourselves. Many times I feel she should die, it would be better, at least all harassment would stop and I could breathe properly, but I feel guilty for having these thoughts after some time.

Although this more traditional configuration remains to an important feature of joint families, the nature of these domestic confrontations are rapidly changing as greater numbers of Indian households are affected by urbanization and a modernization of the traditional value system. Several elderly mother-in-laws reported neglect by their daughter-in-laws as the cause for their DSH event. One such elderly woman reported,

> I crave for love, affection, and closeness from the only people in my world - my son and his family. But my daughter-in-law does not really make an effort to make me feel wanted. It’s been 13 years of their married life, and all these years I’ve harboured this sense of being kept away from my daughter-in-law’s heart. It makes me feel certain emptiness in my life. It fills me with sadness and despair, making me want to cry so often. I have come through so many hardships in life, now I want to experience the love and affection of my near and dear ones, at the sunset years of my life.

In addition, men are indirect victims of this traditional conflict between their wives and their mothers. Several men reported that the personal strain that this causes as having led to their DSH event. One man stated,

> The most significant problem is that my mother and wife can't get along at all, and I get sandwiched in between. This problem has been going on ever since I've been married. It has taken away any peace of mind. It affects my work performance. I have made mistakes at work and my concentration at times is poor. I feel sad and insecure most of the time. I've been increasingly upset and felt that ending my life would be a 'probable' solution.

Help seeking for underlying problems

A majority of both male and female patients (98.9% of men and 96.7% of women) did not seek any recognized professional or other help outside their home for their problems(table 6.8). Instead, patients generally relied upon talking with their families and friends. Significantly more men than women chose to change their lifestyle and somewhat more women (15.1%) than men (6.8%) opted for prayer as recourse for their problems.

Table 6.8:Self-help seeking by sex (%)

Types of self-help	Percent		
	Woman (93)	Men (103)	Total (196)
Exercise	0.0	2.9	1.5
Yoga	1.1	1.0	1.0
Rest	1.1	2.9	2.0
Meditation	1.1	0.0	0.5
Changed Lifestyle	6.5	16.5	11.7 *
Vitamins	3.2	1.0	2.0
Self medication	1.1	1.0	1.0
Home Remedy	2.2	1.9	2.0
Talk with close family	18.3	13.6	15.8
Talk with friends	20.4	17.5	18.9
Prayer	15.1	6.8	10.7
Problem solving	31.2	39.8	35.7

*p<.05 Fisher's exact test.

Patients' narrative accounts revealed that most patients did not consider the DSH event and the experiences related to it as a medical problem, but rather recognized their DSH and related problems as predominantly social issues. Often, the private and personal nature of the patients' problems did not motivate to seek clinical help. Men commonly reported that they preferred to find solutions by themselves and focussed on changing their lifestyles. One such man reported,

> I tried my hand at odd jobs. I tried selling milk packets, selling some pens and torches in the trains, cleaning cars, but nothing really helped much. I'm still looking out for some good company job.

For some men, seeking help for their problems represented a source of embarrassment, dishonour, and was not seen as being appropriate behaviour for a man. One man stated,

> Who can I go to for help regarding this problem? It sounds so embarrassing- a man being harassed by his wife! This is in fact the first time I'm really talking about my problem at length.

In contrast to many of the men's more pro-active choices to change their lifestyles, many women's narratives reflected that they felt unable to change their situations and indicated feelings of helplessness over the circumstances. One woman stated,

> What can I do for myself - I cry and cry. That's all! Then I pray often to God to give me strength - But there's nothing else I can really do to ease things a little.

Women also commonly expressed the need to protect their family's prestige by not disclosing their problems publicly and they even felt ashamed and embarrassed to talk about their problems. One woman elaborated,

> I am fed up with my husband and his suspicious nature! How much can a woman tolerate, especially when it comes to doubting her character and fidelity? Because of all this now my in-laws avoid me. They avoid visiting our place completely. So I cannot expect any help neither from my family nor from his.

Discussion

Although many authors have examined sex differences in rates of DSH and suicide, the explanations are inadequate. These studies neither identify gender-specific risk factors nor explain how these risk factors change DSH trends and patterns according to gender roles. The purpose of this study was to examine gender-specific context of patients' experiences, meanings, and behaviours associated with a DSH event and its underlying problems. We also examined the patients' psychiatric diagnosis, trigger events, and their PDs, PCs and help seeking of underlying problems according to the cultural epidemiological framework.

Clinical context and gender

This study identified the psychiatric disorders associated with DSH. We found that unipolar major depression was a predominant clinical psychiatric disorder among patients in study sample, with a relatively higher percentage of females with this diagnosis, which has also been documented in other studies (Weissman, 1974; Kaplan and Klein, 1989). Stress-related disorders (46.3% of men, 41.7% of women), like adjustment disorders, V-Code and 'no diagnosis' were predominant in the sample, which indicate the important role of social stressors for DSH patients in general, and within a gender-specific context in particular. This finding emphasized the need to look beyond professional diagnoses and consider the social and cultural factors in DSH.

Depressive symptoms reported as PDs were also predominant among the study sample, and were commonly reported spontaneously. When this finding is considered together with high rates of depressive disorders, it raises the critical question of whether the subjective experience of depression and distress are more

predictive of suicidality than objective diagnosis of depression by clinician. Other researchers have attributed DSH to hopelessness in depression (Beck, 1986). In clinical practice, suicidal ideation is an important feature of depressive disorders and may influence a diagnosis of depression. Regarding DSH in women, this is an important concern because DSH is recognised as 'feminine' phenomenon and depression is regarded as a dominant psychopathology in women. As a result, overestimation of depression in DSH, especially in women, is more likely. In addition, social origins of depression such as poverty, severe life stress, and domestic violence are well documented in women experiences (Makosky, 1982; Dennerstein et al., 1993).

Substance abuse, particularly alcohol dependence, was also common diagnosis among male patients in our sample, corroborating findings from several other studies (Canetto, 1991; Kessel and Grossman, 1961; Harris and Barraclough, 1997). It was also identified as a trigger event and a significant feature of PDs and PCs for men and women with DSH. The DSH event is more result of social, financial, and familial issues among addicts than a direct consequence of the clinical diagnosis. Contrary to other findings that have linked living alone to DSH and drug abuse (Hawton et al., 1997), alcoholic patients in this study reported feeling lonely and abandoned in close family relationships. Unlike depressive DSH patients, those DSH patients who are alcohol dependant are more likely to express antisocial behaviour, a hostile attitude towards relatives, and resort to violence. As reported in many patients' narratives, these behaviours often result in more rejection, interpersonal trauma, financial crisis, hostility from family members and stigma.

Typical social context for men and women

The results in this study did not point out significant differences between men and women in psychiatric diagnoses except for substance use disorders among men. On the other hand, narrative and quantitative findings reflected several gender-specific social issues which contributed to DSH by men and women. The typical social context of DSH highlights the need for a gender-sensitive approach to the study of DSH, particularly with reference to high incidence of psychopathology among DSH patients.

The predominance of depressive PDs, social PCs and triggers reported by patients in this study identifies the nature of suffering that may be instrumental in converting suicidal ideations into final actions. In addition, DSH triggers reflect cultural dynamics within a gendered context. Trigger events for DSH that were job specific, financial, and related to substance abuse were associated with men. Interpersonal problems with in-laws and/or spouses and victimization that led to humiliation and helplessness culminated into DSH among women. Men's substance abuse was not only a trigger event for themselves, but the social magnitude of the problem also impacted on their families and wives and was often a trigger event for DSH for them as well. This specifically identifies the collective impact of addictive problems on family members, specifically spouses. The implications for women of this issue need to be addressed further in the field of clinical psychiatry.

Victimization has been identified as the most important indicator of DSH in women (Back et al., 1982; Counts, 1987; Pagelow, 1984; Stephens, 1985). A majority of women from low income countries including Sri Lanka, India, Bangladesh, and Thailand are reported to be victims of violence inflicted by their husbands and other family members. However, this issue remains tacit in clinical psychiatry. In our study, interpersonal problems especially with in-laws and husbands was

predominantly reported by women as triggers, PDs and even as PCs. The significance of interpersonal triggers indicates that they can be a source of distress and be considered the cause of the underlying problems related to DSH. Association of agitation, anger, hostility, and conflict are frequently implicated in interpersonal problems that are related to DSH (Nordentoft and Rubin, 1993;Williams and Polock, 1993). The traditional nature of interpersonal problems with, for example in-laws, marriages, and love affairs are widely acknowledged as associated with suicidal behaviours in patriarchal societies (Adityanjee, 1986; Arcel et al., 1992). The cultural epidemiological approach warns against stereotyped assumptions related gender roles of relational problems and DSH in men. Our study points out that as women with alcoholic husbands are exposed to unlimited hardships and domestic violence, alcoholic men are also liable to be humiliated in interpersonal contexts.

Although several studies have commented on the relationship of unemployment and DSH and suicide in (Platt and Kreitman, 1984; Roy, 1982; Pritchard, 1990), the precise role of unemployment in DSH remains unclear. However, as this study indicates through patients' narrative accounts social and psychological conditions and intense emotional distress associated with unemployment are often accountable for DSH and suicide. Although male dominated societies often advantage men, economical hardship and deprivation can lead to extreme stress among men. More dynamic research on this topic is required to understand if the nature of suicide among men, particularly regarding the relationship of financial and employment-related stressors and suicide. In our study, few women expressed unemployment as a personal problem but several identified problems related to their spouse's unemployment. Several studies have reported that employment is beneficial for women and contributes to prevention of suicidal

behaviour among women (Verbrugge, 1986; Kaplan and Klein, 1989; Canetto, 1992-1993). Nonetheless, these findings need to be tested in Asian countries where women remain socially oppressed and discriminated against and where women's traditional roles remain to be largely defined by commitment to their families.

Complementary contributions of qualitative and quantitative approaches

This study clearly indicated that qualitative data to supplement clinical diagnosis is vital in understanding the nature and fundamental basis of suicidal behaviour. It suggests how and why certain factors make people vulnerable to DSH and suicide and why some other factors protect them from suicide. An acknowledgment of the gender-specific risk factors and the interactive dynamics in evaluating DSH is missing in clinical practice due to dominance of psychopathological approaches. This study contributed an analysis of suicidal behaviour without gendered assumptions of, for example, the protective qualities of marriage for men, and the reverse for women. Our study showed that several factors that are associated with DSH in men such as unemployment, substance and alcohol dependence, which are commonly operationalized through interpersonal relationships and familial pressures, often having serious implications for DSH among women.

Gender specific suicide and DSH prevention strategies

Suicide-related interventions must be gender specific. Greater attention is required to identify those typically vulnerable cultural premises that expose people to distress. In Indian society, the traditional example of the problematic relationship with one's in-laws is one area where focussed interventions are required through a socio-

cultural framework. Further attention must also be focussed in the clinical context on issues such as victimisation, interpersonal problems, and unemployment. Treatment should extend beyond medication and incorporate environmental changes, empowerment of women, or pre-marital counselling to sensitize men and women about issues that may arise after marriage to improve social skills, as well as coping skills. Contextual socioeconomic and political issues that are likely to influence people's living conditions and level of social stresses in terms of DSH reduction should be considered.

To understand suicidal phenomenon as social and personal events, it is essential to give priority to the points of view of affected persons in suicide reduction strategies, even if these personal perspectives may be in contrast to the professional psychopathological view. Hirsch et al., (1983) and Albee, (1990) concluded that primary prevention programmes targeting social and cultural risk factors will be more promising in the field of non-fatal suicidal behaviour than psychopathological approaches alone.

Large-scale studies are indicated to examine cultural epidemiological aspect of DSH and suicide to compare the variety of circumstances in which DSH occurs and how it is explained. These efforts will enhance local community level prevention and intervention strategies that can be applied in similar contexts in other communities. The cultural epidemiological approach in re-examining gender roles in urban settings is essential as gender roles and the interaction between changing social and cultural factors contribute to various mental health and behavioural problems.

Conclusion

In this chapter, we have focused on the cultural framework related to the gendered context of DSH. The cultural epidemiological approach provided an opportunity to examine and understand the dynamic relationship of the underlying problems of DSH, subjective experience of distress, and related help seeking practices. This framework and the application of the multi-methods approach of cultural epidemiology to a gendered study of DSH facilitated the comparison of the conventional clinical diagnoses and patients' experiences, meanings, and behaviours related to the DSH event. This study identified that clinical diagnosis is not conclusively gender-specific, but that social and cultural factors are. Our first conclusion is to look ahead of clinical diagnosis and to integrate the social context more systematically in clinical assessment. The roles of social context we have highlighted in our study seem to be a realistic and sensible approach to plan DSH interventions and reduction strategies. We further emphasize role of triggers which are more gender-specific and have strong cultural foundations in DSH and suicide.

Our cultural epidemiological approach also provides explanations for broader context of underlying patient-perceived problems, as well as variations and exceptions in DSH behaviours. It highlights the need to examine some of the overlooked gender themes based on gender stereotype in literature so far showing how the urban milieu influences gender-specific features of DSH. This approach to study of DSH makes it possible to consider perspectives of affected persons concerning the meaning of DSH with respect to their gender roles; It makes possible to consider not just a social epidemiology of sex differences, but also a cultural epidemiology of gender differences. Finally, such studies are expected to be

effective in developing local community intervention and prevention programs for DSH, which may have wider applications in gender sensitive programmes.

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Chapter 7

Summary and conclusions: Implications for clinical practice, mental health policy and research

Shubhangi R. Parkar

GENDER AND THE CULTURAL CONTEXT OF URBAN MENTAL HEALTH IN MUMBAI

Introduction

As urbanization continues to progress inexorably, projections suggest that half the world's population will live in cities by the year 2007. The results of this population growth and demographic shift have well-recognized implications for various aspects of urban health planning (e.g., economic structures, spatial strategies, urban services, institutional development, managerial problems), especially in Asian megacities (Brennan and Richardson,1989). Both the number and the size of cities are increasing, and the pace of growth of megacities (population of 10 million or more) is especially impressive and challenging. Urban planners distinguish issues that result from the rapid growth rates (urbanization) from those arising from the sheer static size (urbanicity), identifying particularly pertinent considerations that may be distinctive for each (Vlahov and Galea, 2002).

Table7.1: Sex ratio in Indian cities with a population of 1 million and more.*

Rank in 2001	City - Urban Agglomerations	Population 2001			
	(3,000,000 + Population)	Persons	Males	Females	F/M ratio
1	Greater Mumbai	16,368,084	8,979,172	7,388,912	0.82
2	Kolkata	13,216,546	7,072,114	6,144,432	0.87
3	Delhi	12,791,458	7,021,896	5,769,562	0.82
4	Chennai	6,424,624	3,294,328	3,130,296	0.95
5	Bangalore	5,686,844	2,983,926	2,702,918	0.91
6	Hyderabad	5,533,640	2,854,938	2,678,702	0.94
7	Ahmadabad	4,519,278	2,397,728	2,121,550	0.88
8	Pune	3,755,525	1,980,941	1,774,584	0.90
	Total	**68,295,999**	**36,585,043**	**31,710,956**	**0.87**

*Source: Office of the Registrar General and Census Commissioner, India, 2001.

India already has three mega cities (Mumbai, Kolkata and Delhi), and the projected growth rate of 2.74 for Mumbai over the period from 1995 to 2015 is the

highest of any megacity in the world (United Nations,1996, quoted by Bhattacharya, 2002, Table 2, p. 4221), placing it on a course to become the world's second largest megacity by 2025. The nature of urbanization in India, as in other developing countries, is notable for the demographic patterns of inward migration. In addition to families, many men come from the countryside to work, while also maintaining homes and families in rural areas. This results in a preponderance of males in the population of Indian cities, especially in the fastest growing large cities of Mumbai and Delhi (Table 7.1). This demographic pattern and the mix of subcultures result in living arrangements and lifestyles that are also highly relevant to considerations of gender in the urban mental health research studies presented in this thesis.

Planning for urban health is an especially challenging priority, and in view of the impact of the projected epidemiological health transition, questions of urban mental health become increasingly central to health planning (Strike et al., 2002). The prominence of mental health problems and other chronic disorders has also been highlighted by widespread acceptance of the Disability-Adjusted Life-Year (DALY) as the preferred measure of disease burden (World Bank 1993; World Health Organization 1994).

With increasing attention to health on the agenda of urban planning, the need for information about changing epidemiological patterns has become especially timely (Harpham and Molyneux, 2001). Psychiatric epidemiological data made it possible for the burden of disease studies to indicate the larger-than-expected impact of both mental illnesses and disorders of behaviour and lifestyle. As important as the basic psychiatric epidemiology has been, however, to document the disease burden and to shape priorities, it does not provide much of the relevant information needed to account for mental health problems that do not meet international criteria

for mental disorders, but which nevertheless are recognised as mental health problems locally. In charting a course for epidemiology to serve the field of mental health over the next decade, Wittchen (2000) argued for the importance of considering subthreshold conditions, which may indicate relevant clinical and community priorities in the absence of criteria-based disorders.

Wittchen's attention to disability and impairment has been complemented by other approaches to research beyond the mandate of psychiatric epidemiology, but is nevertheless essential for informed practice and planning. WHO's (2001) World Health Report on mental health recognized the diversity of national interests and resources available for mental health planning. Other studies have demonstrated applications of cultural research to local programmes in both rural areas and Mumbai's Malavani slum. Weiss and colleagues (2001) demonstrate the value of a bidirectional process of translation between local and global interpretations of problems, needs and health system responses. Over the past decade, a Harvard study that led to publication of the influential *World Mental Health Report* (Desjarlais et al., 1995) argued for a better balance of international and local priorities and need for research that is more sensitive to the needs of communities locally. This report advocated a new generation of culturally informed epidemiological studies that more precisely represent local representations of mental health problems. It also stimulated development of the Nations for Mental Health Programme at WHO, and it continues to motivate the research approach under the heading of cultural epidemiology pursued in the research studies of this thesis (Weiss 2001, 1997; Raguram et al., 2001; Jadhav et al., 2001).

Cities and mental health

Notable features of city life have direct implications for clinical practice and among these the importance of an appreciation and sensitivity to cultural diversity of urban populations is central. In North America, the concept of cultural competence has gained currency as a skill to be learned in clinical training, not only for psychiatric practice (GAP, 2002) but also for general medical care (Kundhal,2003). In the UK, similar interests in culturally sensitive psychiatric care have also been emphasized as an element of core clinical training (Dien, 1997). Although psychiatry has been most sensitive to international differences across cultures and to multicultural differences in Europe and North America, it has been less responsive to the ethnic diversity of Asian and African cities.

With increasing urbanization, consideration of the multicultural character of these urban populations requires no less consideration. The diversity of ethnic groups and social strata in the cities and megacities of Asia, Africa, and other regions requires no less attention than in North America and Western Europe. The research reported here indicates the impact of the regional mix in both the slums of Malavani and in the sample of patients studied after deliberate self-harm (DSH) at the KEM Hospital. The question of identifying the relevant particularities of social life and emotional experience of these groups requires careful research to ensure mental health services that are appropriately responsive.

Apart from the diverse mix of populations in the megacity, additional complexities of urban life also require consideration and study to determine their significance. Increased mobility within the city and between city and rural villages for migrant labourers introduces an element not only of opportunity but also of instability. Some residents adapt more easily than others to the pace of city life. For many

migrants there is also high potential for frustration and disappointment, as they reach the city with high expectations that may be difficult or impossible to achieve. In Malavani new residents must adjust to the new conditions of a harsh physical and unfamiliar social environment. Such adjustments are features of a process that may result in emotional and mental health problems, or may even result in DSH. Social disadvantage, poverty, and unemployment take their toll and make affected persons in the slums especially vulnerable to serious social and emotional suffering.

The urban slum is a distinctive aspect of city life, characterized by poverty, environmental degradation and hardship. In the effort to understand this experience, however, it may be tempting to search for common, unitary features of life in the slum, just as one might also try to do to characterise a middle-class urban experience. As the ethnography reported in chapters 2 and 3 indicates, the distinction between sanctioned and unsanctioned slums, the variation between Muslim and Hindu communities, the variety of regional groups that live together in the slum, and the various other groupings begin to suggest the complexity of the social environment. A culturally sensitive approach to mental health is not just a matter of identifying cultural differences across international cities, it also requires careful attention to the diversity of experience within such heterogeneous urban settings. It was with that in mind that an ethnographic and cultural epidemiological approach was employed to examine the nature and distribution of varieties of experience, meaning, and behaviour associated with mental health problems. Attention to the social, cultural, and gender basis of these problems was a key consideration for the work in the Malavani community (chapters 2-3) and clinic (chapter 4), and the KEM Hospital clinic, which serves a broader cross-section of the population in central Mumbai (chapters 5-6).

Overview of findings

This research identified local formulations of common mental health problems (CMHPs), as they are known in the community, in contrast with common mental disorders (CMDs) as they are known to health professionals. Each of the chapters elaborated a complementary aspect of this interest. The ethnography of chapter 2 examined the social and cultural features of a rapidly growing slum, representative of the kind of community that usually receives short shrift in the attention of city planners. Findings indicated the nature of the day-to-day hassles of life in this harsh environment and the stressors of a social life, which at its worst is characterised by unemployment, crime, and abuse. Attention to the history of the community; the interplay of features in a deprived physical environment; and the social contexts of violence, addictions, and victimisation were all found to extract a toll on residents in lesser or greater measure in the sanctioned and unsanctioned sections of Malavani.

Chapter 3 elaborated the local language of mental health problems. They were primarily concerned with distress, which was intense, but which was not associated with the stigmatising features of a mental disorder. The local meaning of mental disorders imposed an element of social disapproval, and this stigma could itself impose an additional burden on affected persons. Everyone has problems, however, and frequent references to the *tensions* that characterise life in the community provided a convenient metaphor to characterise mental health problems (whether or not they met professional criteria for disorders) that should concern a community mental health programme. From the local point of view, the problems typically identified as, or attributed to, these tensions were not usually a matter that by itself would justify medical help seeking. In most communities medical services

would be poorly equipped in any event to respond to the social sources of suffering associated with such *tensions*. Findings indicated, however, the issues that community supports would need to address, which often had more to do with social, economic, and development issues than clinical concepts of psychiatry. They suggested the need for cooperative efforts linking the health system with government agencies and NGOs to achieve effective balance of interventions for mental health promotion, and for illness prevention and treatment.

Unlike most people in the community for whom common mental health problems were mainly difficulties to endure personally, rather than conditions likely to benefit from treatment, some people came for treatment and were identified through screening in the primary health centre (PHC) as suffering from a mental health problem. The study reported in chapter 4 found that most of these people presented their problems initially with reference to somatic symptoms, rather than emotional distress. One woman, for example, who was repeatedly physically abused, came for treatment only to get medicine to treat the pain from her beatings, without hope or consideration of prospects for relief from the abuse itself. It was considered shameful for many such victims to speak of such things, as this would itself add to the pain. Instead, the social and emotional aspect of their problems typically remained unspoken unless probed. Although this PHC had established a mental health clinic, most people regarded the health centre as concerned with physical disorders, and a place where they did not consider social and emotional problems to be relevant.

The setting for the study of DSH in chapters 5 and 6 was the KEM Hospital in central Mumbai, located in a middle-class neighbourhood, and a respected institution where people might come from various corners of the city and surrounding areas. Striking findings from the research showed that nearly half the patients did not meet

criteria for an Axis-I psychiatric disorder. These patients readily spoke of various stressors, losses, and problems in their family and social life. The research attended to the need for integrating complimentary socio-cultural and clinical perspectives. The research on deliberate self harm examined the relationship between clinical diagnosis based on DSM-IV and patient perceived determinants of suicidal behavior based on EMIC framework. This comparison guides complementary psychiatric and cultural epidemiological assessments of suicidal behavior.The patients typically did not view the kind of stress that led to their suicidal behaviour as related to the kind of mental health problems for which they might consider medical or psychiatric care appropriate. Furthermore, they also appeared to prefer speaking about the social stressors, which were more likely to evoke a supportive response, than speaking about emotional problems that appeared to them more likely to evoke an indifferent or disapproving response.

Chapter 6 examined the role of gender, gender-specific triggers and features of DSH associated problems and their social settings. Expected gender-specific contexts were identified, such as alcohol and other substance dependence disorders among men and victimisation among women. The focus on gender provided useful information and valuable insights, but it also had limitations, and the gender focus required consideration in the broader context of social issues. Furthermore, a number of individuals also described their problems in terms that contradicted the gender stereotypes. For example, although women were more likely to be troubled by marital problems and their in-laws, about a third of male respondents also reported such problems. Our findings highlight, that in terms of distress, cultural and social context is an important consideration and gender specific generalization of psychiatric disorders based on epidemiological studies may be inappropriate picture

of actual CMHPs. The study also indicated that men are likely to be as depressed as women are and their depressive symptoms may be noticeable more on probing. Suicidal thoughts were significant distress for women (70%) than men (45%) and notably were expressed more on probing (63.3% women and 41.7% men).Hostility as a feature of distress was expected to arise more among men, but actually it was reported more frequently as a problem by women in their account of the underlying problems leading to DSH. Although men were indeed more typically concerned about unemployment and financial problems, the middle-class structure of male breadwinners and female housewives has begun to erode in urban middle-class communities, and far more so in the slums. In Malavani, many women worked at jobs and contributed to family income, although they were often required to hand their earnings over to their spouse. Consequently our these results, convey the need to understand the language of communicating mental health problems beyond these diagnostic classification.

Implications for clinical care of mental health problems

Findings suggest that although psychiatric diagnostic assessment is an important task in the course of clinical management, it has limitations in accounting for many of the relevant problems encountered in the primary care settings of the Malavani slum and in the KEM clinic treating patients after DSH. The concept of CMHPs proved to be especially useful for considerations of an effective community mental health system and for identifying and discussing patients' problems in the primary health and DSH clinics. The concept of CMHP is not recognized in the international psychiatric diagnostic manuals (DSM-IV and ICD-10), but it is essential for understanding how patients make sense of their suffering and relate their

problems to other aspects of their lives. An understanding of culturally relevant local terms facilitates bidirectional communications and a therapeutic alliance in clinical practice, which can be expected to enhance recognition of disorders in the clinic and treatment compliance.

The cultural epidemiological framework specifies the local taxonomy and essential features of CMHPs with reference to illness representations as patterns of distress, perceived causes, and help seeking. Findings from such study clarify the features of the problems that are locally relevant and require attention. Like a considerable body of other research on somatization in India and elsewhere, these findings suggest that people portray their social and emotional problems through somatic symptoms. Clinicians, however, are less attentive and less able to respond if they do not understand and cannot interpret the vernacular of illness- and problem-related experience, meaning, and behaviour, which are related to CMHPs and the triggers of suicidal behaviour. Although patients typically present with an account of somatic symptoms, findings show that when probed, they recognise and can articulate the emotional and social features of their problems. An appreciation of the cultural epidemiology ensures that the clinical dialogue addresses both clinicians' and patients' priorities, and that these make sense to one another in the course of the clinical interaction.

Implications for community mental health policy

Studies of the burden of disease identify professional priorities for mental health policy. To formulate policy that addresses the needs specified by these priorities, our findings indicate how these priorities may be translated into the language of CMHPs and the triggers that are identified from study of DSH.

Recognition of the importance and potential implications of these CMHPs is not just a medical matter, but a collaboration that should involve a range of community services, such as schools, community groups, development organizations, and government agencies. Findings from the focus on gender are especially relevant for discussion in both women's groups and organizations composed of men. Findings from the study reported in chapters 5 and 6 suggest that community-based prevention of DSH requires careful attention to the social and gender contexts of suicidal behaviour.

Preventing suicidal behaviour is not just a matter of screening for disorders of known risk, but rather finding ways to make it acceptable to seek help for the kind of stressors that were identified as triggers for DSH. In particular, the triggers of DSH should be made known through community activities at various levels—through community development workers, teachers and students. Participatory programmes involving community groups and schools should make use of the findings from cultural epidemiological study to explain the nature and consequences of CMHPs and to engage participants in promoting awareness of the problems, appropriate supports and referral. As a practical matter, this research was undertaken in the context of community mental health programmes in Malavani and central Mumbai, where findings are guiding the further development of community interventions.

Implications for research

Research reported in this thesis demonstrates how cultural epidemiology supported by ethnography may complement psychiatric epidemiology to guide clinical practice and mental health policy. Collectively, the studies in this volume suggest the value of ethnographic data for identifying categories of experience,

meaning, and behaviour, which are useful to clarify locally important features of CMHPs in practical terms. With a focus on urban health, they complement recent rural community mental health studies in West Bengal (Chowdhury et al., 2001).

It is also anticipated that cultural epidemiological studies that have clarified mental health problems and needs for programme activities in the slums and neighbourhoods of Mumbai will be applied in other settings. As indicated at the beginning of this chapter, demographic patterns of urbanization and important features of cultural context made gender an important focus of interest in these studies. As a cross-cutting feature of various mental health and general health problems, the current focus on gender in these studies is likely to provide a framework for comparative studies of illness of theoretical and practical significance. It is hoped that the research reported here will be useful to other researchers, and to clinicians and policymakers who may also wish to apply these methods and make use of findings in other settings.

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- Administration and planning in medical services and medical education. Research activities planning and implementation, teaching in University College of Mumbai University.
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- Examiner for Mumbai University & other Universities in India.
- Expert on Staff Selection Board of Municipal College & Maharasthra Public Service Commission of Maharasthra state.

Teaching experience

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1987 till date	Undergraduate and Postgraduate, SNDT Nursing Students Women's University
1992 till date	De-addiction Training Programme for General Duty Officers of B.M.C. & District Hospital, Conducted by Bombay Drug De-addiction Centre of Excellence, Government of India
2000 till date	VCCT and PPTCT, HIV Counseling Mental Health Issues and suicide intervention for various counselors govern by NACO

Organizational responsibilities

- Member of Executive Committee, Bombay Psychiatric Society
- Hon. Secretary of Bombay Psychiatric Society
- Vice President of Bombay Psychiatric Society
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- 1999-2000: Member of Editorial board of Indian Journal psychiatry.

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Membership in professional societies

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National and International consultation

Oct. 23-25,1995	Technical advisor for substance abuse In the Healthy Women's Counseling Guide; meeting in Vienna, Austria, organized by the UNDP/World Bank/WHO TDR Programme, presented paper concerning female drug addicts
Dec. 11-15, 1995	Key resource person for gender issues, HIV/AIDS and drug abuse in expert forum organized by UNDCP on Demand Reduction in Southeast Asia and The Pacific, held in Hanoi, Vietnam
Feb.3 1996	Expert presenting paper on Drug Demand Reduction, in a workshop conducted by the narcotics cell of Mumbai police department
Mar 18-21 1996	Expert presenting paper on Qualitative Research for Injectable Drug Abuse And HIV Prevention, In INDO-US workshop on Behavioral and Social Research for Injectable Drug Abuse & HIV Prevention
June.7-20, 1996	Technical Expert presenting paper in a national workshop, Review of Course Curriculum of Health professionals and Demand Reduction Strategies, conducted by De-addiction Centre, AIIMS, New Delhi
Jan. 16-17. 2001	Principal investigator for phase-3 multi-centre study of acute mania in Oslo, Norway, for training to administer rating scales (Positive and Negative Symptom Scale, Young Mania Rating Scale, Montgomery Asberg Depression Rating Scale, Clinical Global Impression, Barnes Akathisia Scale, Simpson Angus Scale & Abnormal Involuntary Movement Scale), case record forms and source document completion & adverse event monitoring
July. 28- 29 2003	Technical Consultant to review guidelines for counseling children in context of HIV/AIDS; expert for South India AIDS Action Programme, Banglore, India
Nov. 4-6.2003.	Principal investigator for component of international phase-2 study of schizophrenia, training in Zurich, Switzerland
Jan. 15-17.2004	Principal investigator for phase-3 study of schizophrenia, attended the investigators meeting in Bangkok, Thailand, for GCP training and certification for use of rating scales
Sept. 1- 3 2003.	Consultant and expert, presented a paper on controlled drinking in national workshops organized by WHO and AIIMS in Delhi, India
Mar 20-21 2004.	Expert, presented on the nature and extent of alcohol problems in India – Regional perspective Mumbai, in consultation on the formation of an Indian alcohol policy alliance organized by global alcohol policy alliance (GAPA)
May 10-12, 2004	Expert Co-ordinated session on HIV & psychiatric morbidity and HIV and suicide in national consultation on VCCT curriculum development by NACO, New Delhi, India
June 28-29 2004	Expert participated as resource person in meeting on Indian alcohol policy alliance (IAPA) in Chennai, India.
Sept 28 2004.	Expert attended the workshop as expert on, strengthening the De-addiction Services in the country. In Delhi, India

Awards and achievements

1984	D.P.M. first rank holder in the university
1985	M.D. first rank holder in the university
1994	President’s Award, Bombay Psychiatric Society for scientific presentation
1999	Indian Psychiatric Society's Marfatia National Award for best scientific research presentation
1996	Selected as national-level young scientist to participate in National Workshop for Young Mental Health Professionals, organized by WHO
1999	Indian Psychiatric Society, West Zone’s A.V. Shah Award for best scientific research presentation
2001	Dr. Dwarkanath Kotnis honor for medical services in the community
2001	Bombay Psychiatric Society's L. P. Shah Award for best scientific research presentation
2002	Certificate of Felicitation by Seth GS Medical College and KEM Hospital for providing community services for earthquake victims in Gujarat
2004	Bombay Psychiatric Society's L. P. Shah Award for best scientific research presentation

Courses

- Attended and presented on urban mental health in developing countries, in a workshop on urban health in developing countries, organized by the University of Basel, Swiss Tropical Institute, for Ph.D. students in Basel, Switzerland, September 1999- 2002.