VIEW POINT

Mediating Structural Factors in Mental Health in Indian Context

Mercian Daniel
Consultant, Public Health Foundation of India

ABSTRACT

A structural condition, such as an economic crisis, wherein populations experience large scale job and income losses are generally seen to be related to increased rates of suicides. Mental health problems may be seen either as a response to adjust to such and other societal-level strains. Societies, where inequalities are relatively less, are seen to have better mental health, while in those where resources are unequally distributed have poorer well-being. There has been a growing interest regarding the effects of deprived social environments and its organization on its members' mental health. While particular racial groups in Western countries are more likely to be exposed to mentally unwell conditions, could such an explanation be tenable among specific minority groups in India. Research that looks into the social contexts of minority communities and the ways in which caste in India affects health in general and mental health, in particular, would be able to shed additional insights. Inequalities in terms of access to basic health care among poorer groups and skewed regional distribution of availability, the lack of its provisioning or an absence of it in itself should be considered as an important factor of large scale structural discrimination. A conceptual framework that is able to explain the pathways through which race or caste, gender, and SES interact and operate in complex ways to affect emotional well-being of some of these groups is now seen by many to be a more socially all-encompassing explanation by which these factors are inter-relationally understood better.

Keywords: Structural factors, mental health, Indian context, socio-economic status

The mortality gap in mental illness[1] is a reflection of the broader inequalities existing in society, and that structural processes (i.e. the way society and mental health care is organized) are possibly mediated by certain societal level factors. These factors may either in a proximal or a distal way explains such an unequal difference in mental illness mortality.

Though there are attempts at drawing conceptual and research implications of such an understanding specific to the Indian context, a limitation of such an approach needs to be stated, i.e. these evidences are largely drawn from North American and European countries whose health care and policy environment are vastly different from what it is here.

A *stress, social support, and structural strain*[2] explanation that locates the origins of disorder and distress in the way broader society is organized; distributes this unequally among certain disadvantaged groups; and the role of support networks in offsetting these conditions may offer an understanding into the multiple

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Address for the Correspondence : Dr. Mercian Daniel, C/O: Mr. Harish Awasthi, 2nd Floor, C-5/ 111, Sector: 11, Rohini, New Delhi: 110 085. Email: ekdumercian@gmail.com

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complex realities by way in which societal processes influence mental health. Thus, vulnerability to stress in the form of life events is now being seen as a group and community process also, unlike being originally conceptualized of as a purely psychological concept. For instance, belonging to certain social categories (e.g., racial minority status or gender) differentially determines a members' access to common community resources, whereas life experience of being considered dissimilarly and discriminated upon may pattern their reaction to both stress and illness. Furthermore, exposure to institutional level discrimination on the basis of one's status or position in society and access to resources are seen to result in multifarious mental health experiences. Also, a lot of understanding on the protective as well as deleterious effects of primary social support networks (e.g. family, friends and others) and societal levels of material support (e.g. employment and housing) appears to be emerging, with the former however receiving much more theoretical attention. Unlike acute forms of stress, chronic stress emanating from adverse prolonged social environmental conditions (e.g. unemployment and poor living conditions) is now being seen to play a more critical role in understanding mental health. Therefore, a structural condition, such as an economic crisis, wherein populations experience large scale job and income losses is generally seen to be related to increased rates of suicides. Recent reports from India indicate towards such an association as over the past two decade debt and rural distress have led scores of farmers to commit suicide. Moreover, as job related stress and distress appears to be rising in North America owing to the recent financial crisis, suicides resulting from job losses among the working class in India, probably as a result of company retrenchment policies, are being reported in recent times. Though most explanations of mental disorders indicate that such macro level strains as a result of social and economic changes tend to be associated with increased rates of mental disorder or mental hospitalization in certain groups, recent reports by NGOs and mental health workers from India indicate a steady rise in callers and visits to their services.[3] Thus, mental health problems may be seen either as a response to adjust to such and other societal-level strains or to a group and its individuals' participation in societal processes.

Taking a cue from a classic study done by Faris and Dunham [4] among admitted patients with serious mental illness, it is therefore not surprising that mental health problems are selectively and unequally distributed among the population in general and particularly among the low socioeconomic classes. Studies have documented that the social conditions of certain disadvantaged groups, e.g. Afro-American, migrant Hispanics and women, expose them to higher levels of persistent stressors, e.g. unemployment or poverty, while they lack (access to) institutional support systems that enhance individual and community coping resources to tide over such difficulties. Though the social context in India may differ in some ways, poor neighborhoods in the United States indicate high levels social inequalities such as racial segregation, unemployment, housing insecurity, crime, and substance use among others conditions; it would be interesting to research these in an urban slum or a caste based community in India, as these structures in themselves are seen to affect the mental health of such groups members in a distressing and deleterious manner.[5] Evidence show gender differences in terms of men and women experiencing varying types of mental health problems in general and women, in particular, exhibiting higher levels of common mental health problems like anxiety and depression. Understanding on the social context of distress and depression and its relationship to high degrees of societal integration and regulation may be able to shed some insight into why girls are socialized to emulate the other gender, i.e. boys, and to adhere to dominant patriarchal norms in society that control (while disturbingly normalizes) their sexual behaviors. On the other hand, societies, where inequalities are relatively less, are seen to have better mental health, while in those where resources are unequally distributed as a whole have poorer well-being.[6] Therefore, in recent times, there has been a growing interest regarding the effects of deprived social environments and its organization on its members' mental health.

Persistent social and economic stressors, viz. poverty, unemployment, marital and family disruption, discrimination etc. are seen to be unequally distributed

among specific minority groups. Research done in North America and Europe indicate a strong association between race and Socio-Economic Status (SES) as American Indians, Hispanics, Blacks, and subgroups of the Asian and Pacific Islanders are seen to be lower down the SES ladder than their White counterparts.[7] While particular racial groups in these countries are more likely to be exposed to mentally unwell conditions, which in the long run makes them increasingly vulnerable to mental distress, could such an explanation be tenable among specific caste and religious minority groups in India. Interestingly, emerging literature in this area suggests SES to be a part of the causal pathway by which race affects health status,[8] and that variation in SES among and between different racial groups further illustrate this point. What is important to understand here is that such social inequalities which lead to unfavourable health outcomes are to some extent a consequence of being economically discriminated upon because of the way in which societal structures are organized and operate. Though evidence on the health among Afro-Americans groups in the United States for many years indicates that prejudice and discrimination can affect their health in a harmful manner,[9] in recent years there has been a phenomenal interest in studying this relationship in particular.[10] Earlier measures that examine stress processes miss out on such macro-institutional factors along with considering racial discrimination in itself as an important part of such processes experienced by the minority population.[11] Thus, research that looks into the social contexts of minority communities and the ways in which race (and caste in India) affects health in general[12] and mental health, in particular, would be able to shed additional insights into these complex issues.

Inequalities in terms of access to basic health care among poorer groups and a skewed demographic or regional distribution affecting its availability, as well as the lack of its provisioning or an absence of it in itself should be considered as an important factor of large scale structural discrimination. Thus, it is a matter of some concern that the District Mental Health Program (DMHP), a flagship program of the Govt. of India, which envisages to provide primary mental health care to the people, was only a few years back seen to be operational in as less as 20 percent (i.e. 125) of all the districts (i.e. 625) in the country.[13, 14] Though stigma and ignorance were earlier believed to be the primary reasons for not availing mental health care, there appears to be an overall increase in the utilization of both public and private mental health care services in the country. However, this does not in any way indicate the pattern of such use according to SES in spite of evidence that shows such a relationship of this kind, i.e. not availing treatment for mental health problems tend to be higher among people in low SES.[15] Mental illness mortality among hospitalized patients in North America and Europe has been reported to be quite high and that quality of healthcare has been studied as a factor to explain such a gap. Though evidence to understand this is not forthcoming in India, a joint study done by NIMHANS and the UNHRC may shed some light on such issues in developing countries as the report published in the early 1990s paints an abysmal picture of human rights violations in large state run hospitals.[16] Unregulated and non-licensed psychiatric practice in India has also resulted in a proliferation of such treatment and care centres largely operated by private and religious trusts. Not many years back in 2001 the Supreme Court of India recognized the gravity of this problem in the wake of 28 residents in Moideen Badhusha Mental Home at Erwadi in Tamil Nadu were found charred to death and chained to their beds.[16] Disparities also seen in mental health funding and manpower deficits at the global, regional and local levels indicate that people from low SES are the ones to be most affected.[18]

A conceptual framework that is able to explain the pathways through which race or caste, gender, and SES interact and operate in complex ways to affect emotional well-being of some of these groups is now seen by many to be a more socially all-encompassing explanation by which these factors are inter-relationally understood better. If one is to believe that unequal societies produce similar institutions and policies, then a conceptually inclusive framework should not shy away from looking into the possibility of the healthcare system itself perpetuating such forms of structural discrimination, while also being able to deliver improved healthcare services to the poorer sections of society. Emerging

interdisciplinary research that integrates many of these structural level factors, thus help us in better understanding the relationship between SES and mortality differences in mental illness.

REFERENCES

1. Lawrence D, Kisely S, Pais J. The epidemiology of excess mortality in people with mental illness. *Can J Psychiatry* 2010;55(12):752–60.
2. Horwitz AV, Scheid TL, editors. A handbook for the study of mental health: Social contexts, theories, and systems. 2nd ed. New York: Cambridge University Press; 2010.
3. Chatterjee P. Economic crisis highlights mental health issues in India. Lancet. 2009;9670(373):1160-1.
4. Faris REL, Dunham, HW. Mental disorders in urban areas: An ecological study of schizophrenia and other psychoses. Chicago: University of Chicago Press; 1939.
5. Stockdale SE, Wells KB, Tang L, Belin TR, Zhang L, Sherbourne CD. The importance of social context: neighborhood stressors, stress-buffering mechanisms, and alcohol, drug, and mental health disorders. Soc Sci Med. 2007;65(9):1867-81.
6. Marmot M, Wilkinson RG, editors. Social determinants of health. New York: Oxford University Press; 1999.
7. Williams DR. The health of US racial and ethnic populations. J Gerontol B Psychol Sci Soc Sci. 2005;60 (Special Issue 2):S53-62.
8. Cooper R, David R. The biological concept of race and its application to public health and epidemiology. J Health Polit Policy Law. 1986 Mar 20;11(1):97-116.
9. McCarthy JD, Yancey WL. Uncle Tom and Mr. Charlie: Metaphysical pathos in the study of racism and personal disorganization. Am J Sociol. 1971;76(4):648-72.
10. Paradies Y. A systematic review of empirical research on self-reported racism and health. Int J Epidemiol. 2006;35(4):888-901.
11. Williams DR, Neighbors HW, Jackson JS. Racial/ethnic discrimination and health: findings from community studies. Am J Public Health. 2003;93(2):200-8.
12. Ahmed AT, Mohammed SA, Williams DR. Racial discrimination & health: Pathways & evidence. Indian J Med Res. 2007;126(4):318.
13. Kumar A. Mental health services in rural India: challenges and prospects. Health [Internet]. 2012. [cited 2017 Feb 09]. Available from:http://file.scirp.org/pdf/Health20111200001_61030332.pdf
14. Sahu KK, Sahu S. Rural mental health in India. Dysphrenia. 2013;4(1):7-11. [Internet] [cited 2017 June 11]. Available from: http://www.ojpas.com/2013_4_1_07-fulltext.html
15. Gadalla TM. Comparison of users and non-users of mental health services among depressed women: a national study. Women Health. 2008;47(1):1-9.
16. National Human Rights Commission. Quality assurance in mental health. New Delhi: National Human Rights Commission. 1999.
17. Krishnakumar A. Deliverance in Erwadi. Frontline. 2001; 18(17):18-31.
18. Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. Lancet. 2007;370(9590):878-89.

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