Article

Isliye dard hota hai:[1] Women's Mental Health Issues in Poor Households of India

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Abstract

Mental health of women is often looked at from a biomedical lens. Mental health issues resulting out of globalising economic and cultural forces are generally neglected. This often implies that social problems are understood as individual problems. Increasingly discourses in sociology and anthropology explore mental health in bio-cultural terms where social structural arrangements are said to contribute majorly to the phenomenon of psychosocial distress. There is a need to explore the ways in which the social and economic conditions which structure women's existence as part of poor urban households require attention. This article moves away from the mental illness paradigm through which distress of women is usually understood. With the help of narratives, it seeks to explore the distress of women in the context of the community they live in and the gender roles they negotiate.

Keywords

Urbanism, women, mental health, poverty, household

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Introduction

World over, urban areas are growing very fast and every week nearly 1.3 million population get added to already overcrowded urban settlements. The urban population of developing countries is projected to grow at an average annual rate of 2.4 per cent, twice the annual population growth rate of 1.2 per cent in the developing world (United Nations Population Division, 2002). Because of this rapid population growth, rising poverty levels, weak policy frameworks and inadequate public institutions, urban areas in developing countries face an enormous challenge to provide adequate infrastructure; shelter; basic services including access to safe water, sanitation, education and basic health services, employment opportunities; and ensure food security. Growing urban poverty is becoming a major concern. Within urban areas, the urban poor face many more health risks than the average urban residents. Health conditions of urban poor are sometimes even worse than they are for the rural poor (World Health Organization, 1998). Within the urban poor, women are likely to be more affected as they have less access to resources, lower employment opportunities and face greater restrictions in accessing credit (Arun, 1999). Caste further impinges on women's lives intersecting with poverty and their autonomy (Deshpande, 2002; Dube, 1996). Poor women generally assume the least favoured jobs, often facing higher risks of exposure to pollutants and hard labour practices (Doyal, 1995). Social exclusion and lack of voice for poor urban women increases their vulnerability to ill-health and violence. This has a significant impact on their mental health. Community-based studies of mental health in developing countries suggest that 12 per cent to 51 per cent of urban adults suffer from some from of depression (see 16 studies reviewed by Blue, 1999). In India and other low-income countries, common mental disorders were about twice as high among the poor than the non-poor and there is a higher prevalence of these disorders among women, especially women with lower levels of autonomy (Patel et al., 1999). In different community studies by Patel et al. (1999) in India, common mental disorders were found to be associated with economic difficulties, limited decision making agency and low levels of family support. Little research has been done on the linkages between the quality of living environment and the subsequent mental health of people living in that environment.

This article seeks to explore the relationship between urban living and mental health problems with respect to women living in an urban slum. This is because anxiety and depression are typically found to be

more prevalent among urban women than men and are believed to be more prevalent in poor than in non-poor urban neighbourhoods (Almeida-Filho et al., 2004). In exploring the relationship between urban environment and mental health, we first look at the various socio-cultural, economic and political forces that influence the everyday lives of women living in a slum. In this we specifically explore the effect of globalisation on distress. This is done keeping one narrative as central; in this narrative the woman reveals the influence of macro-forces in her everyday life and the way they combine to influence her mental health. Intersecting narratives of other women in the field site support her narrative to illustrate that mental health issues facing women currently are not individual issues but are a result of an interaction between the individual and the social.

Environment and Mental Distress

If environment is broadly the entire context of human experience—geographical, physical, social, psychological and economic aspects of life then we can talk about culture as acting as an intermediary between human and environment. Culture may thus be viewed as both a product and a producer of urban environment (Schell, 1997). Urbanisation has brought its own set of problems pertaining to mental health and well-being. Mostly because of increased speed and decreased costs of communication and transportation, cities are growing increasingly diverse in their population. Consequently, cultural factors have taken centre stage in the understanding of urban mental health. In exploring the relationship between culture and mental health, we work on the conceptualisation of culture given by Appadurai (2004) which includes aspiration as a strong feature of cultural capacity. Aspirations are related to wants, preferences, choices and calculations; globalisation has created gaps between aspirations and realities which is leading to different kinds of mental health issues.

Culture and Mental Health

Urban environments encompass a great deal of economic and social difference. Socially defined groups (e.g., ethnic groups, the poor, minorities and homeless) are created through cultural consensus about what is

acceptable, right and normative. There is economic variation across these groups of people and urban environments are the loci where there is great disparity among groups of people living in proximity (Aday, 2001; Nguyen and Peschard, 2003; *Panel on ethnic and racial disparities in medical care convened by Physicians for Human Rights*, 2003). This very characteristic of disparity in the urban environment leads to relative poverty and, therefore, discontent amongst people. This has been increasing with the effects of globalisation. Changes in identity, both individual and group, and the assimilation of national markets into a single sphere may be said to be attributable to globalisation. Like globalisation, culture is an abstract concept that also covers a broad territory. It refers to patterns of perceiving and adapting to the world. Culture is reflected in the learned, shared beliefs, values, attitudes and behaviours characteristic of a society or population. Although there is more than one definition of culture, there seems to be an agreement that culture is learned and shared, it is dynamic and ever-changing, and it is the way people structure and adapt to their internal and external environments. Globalisation has been phenomenal in its impact on culture; no longer are cultures living in relative isolation from one another so that attitudes, practices and beliefs evolve separately in different cultures. Instead, cultures are integrating, with values and beliefs from one culture finding new homes in other cultures.

In spite of globalisation or perhaps because of it, communities often tend to cling to their notions of understanding of certain concepts; this can be clearly seen in the field of mental health. Therefore, it is important to understand the local understandings of psycho-social distress. It is frequently seen that the medical/psychiatric viewpoint chooses to ignore the socio-political conditions that define mental illness at a particular point of time and thereby ignores the cultural understanding of the illness.

Gananath Obeysekere (1985) argues that sentiments of sorrow and revulsion towards one's body in South Asia are irrevocably rooted in Buddhist cultural traditions, and are in fact highly valued by some Buddhists who meditate on these sentiments in order to seek a more enlightened understanding of the world. Anything that might be labelled as depression in the West, therefore, assumes radically different set of meanings among Buddhists in South Asia. Other factors to consider are the culturally constituted 'idioms of distress' (Nitcher, 1981) that pattern how people signal and embody distress. Nichter (1981) also presuming limits on the ability of south Indian women to ventilate or verbalise 'distress' within or outside of home, finds a somewhat broader range of

alternative idioms of distress in addition to 'illness idioms': eating disturbances, obsession with purity, reports of evil eye, spirit possession and involvement in Bhakti cults. In other studies that combine psychoanalytic and anthropological theory, Obeysekere (1985) documents the ways in which the unconscious sentiments of desire and guilt motivates the lives of Sri Lankans and sometimes lead to situations of distress, illness or frail cures as manifested in demonic attacks, divine possession and ritual practices.

Cultural definitions are further evident through the work of Kakar (1982) who said that in the Indian context psychiatric difficulties are usually not seen from the point of view of the medical model; largely they are seen in the context of healing. Healing in its manifold aspects is a central individual and cultural preoccupation. In India there are a wide variety of people involved in the tradition of psychic healing which include besides the few psychiatrists, vaids, hakims many of who practice 'psychological medicine'. There are also palmists, horoscope specialists, herbalists, sorcerers and a variety of shamans whose therapeutic efforts combine elements from classical Indian astrology, medicine, alchemy and magic, with beliefs and practices from the folk and popular traditions. And then, of course we have the sadhus, swamis, maharajas, babas, matas and bhagwans, who trace their lineage to the mystical–spiritual traditions of Indian antiquity and claim to specialise in the restoration of moral and spiritual well-being (ibid.).

Another aspect of healing has been documented by anthropologists while studying different religions of the world. These reveal that when psychiatric difficulties are seen in the context of healing then there is an acknowledgement that the suffering is real. This can be further understood by examining the concept of spirit possession. This is the idea that supernatural personalities can enter, own and use people while they are in an 'altered state of consciousness' or trance state. Frequently women are associated with spirit possession, one theory talks of women trapped by the double standards of male–female relationships or by the socioeconomic conditions of colonialism (Thapan, 2006). The use of spirit possession as a means of resistance shows that since woman's choices are located within their everyday experience, they speak from within the multiplicity of their experience and location. They use several and varying acts of resistance that need not necessarily fall into a universal pattern, but remain embedded in local acts or modalities of agency evolving from individual ways of perception and action (ibid.). These cults are seen as ways in which powerless people work out their anger of and fears about more powerful people.

In the newer medical anthropological model, biological and cultural factors dialectically interact. At times one may become a more powerful determinant of outcome, at other times the other but most of the time it is the interaction (the relationship) between the two which is more important than either alone as a source of amplification or dampening of disability in chronic disorder. Furthermore, that dialectic may transform the biology just as it alters social relationships (Kleinman, 1987: 450). The relationship between culture, urban spaces and mental health is not linear and there is a lot of interface between them. We have chosen to discuss them in different sections for the sake of simplicity and highlighting the effects of both.

Urban Spaces and Mental Health

Within urban spaces, multiple realities exist; the everyday life of a woman living in a poor urban household is very different from a woman who stays in a poor village household or one who resides in a household with a better socio-economic status in an urban area. This is because places by their very nature exert a strong influence on the way our lives are structured. Thus:

> Places have multiple meanings (for their inhabitants) that are constructed spatially … (and) need to be understood apart from their creation as the locales of ethnography … (more crucial is to) raise questions about how the anthropological study of place relates to experiences of living in places. (Rodman, 1992: 641)

The concepts of mental illness, distress are not just determined by the structures present in society but are also mediated by the interaction between the structures and individuals. Bourdieu's work on the interaction between field and habitus offers explanatory potential. The concepts of field and habitus offer the possibility of exploring the significance of power relations in the details of ordinary lives and of understanding how the structural realities of the economic, cultural and social are internalised over time to become habitualised, unconscious practices. According to him social structures inculcate mental structures into individuals; these mental structures in turn reproduce or change social structures (Bourdieu, 1988[1984]). Therefore, it becomes important to understand the existing structures that affect the definitions of women's distress and women's agency in mediating this.

Blue (2001: 219) in her paper points out the reasons for which mental health needs to be studied in urban areas. She explains that it has been accepted that it is poverty rather than urban or rural residence that plays a role in creating high levels of stress and subsequent mental ill-health. She says that focusing on urban areas makes sense as majority of the world's population will live there in the future and urbanisation has resulted in changes in social structure which have an impact on mental health. Vikram Patel (2001) argues that in the Asian context, there is a cycle of poverty and mental ill-health. Poverty causes emotional distress due to insecurity: the stress of making ends meet, coping with emerging difficulties and crisis and indebtedness and dependency on moneylenders. Therefore, in the case of common mental disorders, with their vast array of associated social and environmental determinants, it is important to go beyond the individual-exposure risk model. Lacking the basic goods and facilities for quality of life to be maintained is only one aspect of poverty—how people relate to the deprived circumstances that they find themselves in and the social circumstances is another, less well-analysed aspect. Migration, urbanisation, globalisation bring about rapid changes in an individuals' society. Urbanisation has created major transformations in the lives of women which have had consequences on women's health, particularly for women's mental health. In a study of Mumbai, Parker et al. (2003) give an account of the stresses that affect men and women in a slum community in the north of the city. Men in this community are deeply frustrated by the lack of work, and seeing few prospects of improvement, many of them fall into a pattern whereby idleness is mixed with helplessness and hostility. This has increased the burden on women, especially when their spouses retreat into alcoholism or lash out in episodes of domestic violence, infidelity and deliberate humiliation. Women face violence in a number of situations, in fact many of their physical problems have roots in the stress that they face in their daily lives. A recent study of 1853 persons who came to a general health facility found that 193 (10.4 per cent) had psychological problems. Most were women, in the age group of 16–45 years who had come to the facility from a far greater distance than those with physical disorders. For a majority of the group 'the cause of stress lay in personal and family life' and specifically, for 10 per cent, marital and sexual reasons were the main cause of distress. It would be fairly safe to hypothesise then that while a sizeable percentage of women's health problems lie rooted in familial dynamics and tension-ridden relationships, more often than not they get treated for physical disorders (Karlekar, 2005). In deprived countries, women bear the burden of responsibilities of being wives,

mothers, educator and carers; at the same time a part of labour force. In 25–33 per cent households, they are the prime source of income. Significant gender discrimination, malnutrition, overwork, domestic and sexual violence add up to the problems. Social support and the presence of close relationships (more commonly observed in rural society) appear to be protective against violence. The women have a greater role to play in the urban setup, but the rise in hierarchy in society that should rightfully accompany this increased demand on them is still missing (Trivedi et al., 2008).

Women, Households and Mental Health

The household, in more ways than one, is located at the centre of women's lives, being both the object of and the locale for a large chunk of their daily activities. Historical, social, cultural and economic factors directly or indirectly influence a woman's position in the household. Often a sharp distinction is made between the domestic and public sphere and since women are identified with the domestic, the larger macro forces are somehow delinked from their lives, and therefore, their lives are less important as compared to men whose lives symbolise the public sphere.

By situating our analyses of mental health in terms of women within households; we seek to emphasise the political nature of the household and how this influences the well-being and emotional health of women. Olivia Harris (1981) has pointed out that relationships between household members are not defined by the nature of the household itself, but by social, economic and ideological relations outside the unit. Households are important in feminist analysis because they organise a large part of women's domestic/reproductive labour. As a result, both the composition and the organisation of households have a direct impact on women's lives, and in particular on their ability to gain access to resources, to labour and to income (Moore, 1988: 55).

The roles of women within the household became even more complex with the global changes that have taken place. The structural adjustment programmes (SAPs) that were imposed on the indebted Third World countries in order to bring their economies under the discipline of the neoliberal 'free market' have had disastrous consequences, particularly for poor women. The austerity programme that IMF prescribes under SAPs usually consists of devaluing a country's currency, privatising

state—run enterprises, dismantling social programmes for poor, such as, primary health care, free education and subsidies for basic food items and promoting export-oriented production. Increased poverty and social polarisation, sparked off by neoliberal austerity programmes have led to more violence against women, social strife and even ethnic, religious and racial wars (Chossudovsky, 1994).

The poor economic status of women increased their dependence on state welfare policies; in the late 20th century government policies of privatisation have eroded such welfare provisions. Reduced work opportunities for women without the safety net of state welfare have led to increased poverty among women. This has increased their participation in marginal unregulated activities, such as, street vending, working as domestic servants, prostitution and so on. The new emphasis on cost-efficiency in different fields has led to more exploitation of women's labour, for example, hospitals becoming 'more efficient' means that patients are discharged earlier, medicines are not available for free and women's invisible family labour is compensating for this situation. The stretchability of this invisible labour resource has its own limits, as women's health gets ruined. Women face the lack of access to resources or outlets outside the household, inner-household markets are biased against women, and intra-household distribution of income and decision-making of expenditure is distorted (Elson, 1994). In a poor urban household these and other issues combine to make life more difficult for the women.

As a category, women have not controlled the means of production or of reproduction; in addition they have routinely been sexually abused as well. Rape has been systematically used by men of every class and race to destroy women within their family or community and during wars, wives, mothers and daughters of the enemy. In India, sexual abuse of women has implications for maintenance of caste boundaries as well. The mechanisms for the functioning of the principles of hierarchy, separation and interdependence characterising caste operate not through individuals but through units based on kinship. Control over female sexuality is critical to purity and boundary maintenance between castes. Women are guardians and conduits of purity and honour of the caste. But to achieve this goal at the level of institutions, the family-household is important. Purdah, restrictions on mobility, stress on virginity before marriage, anxiety regarding early and appropriate marriage of girls, stigma of illegitimate offspring and abandonment, ideological valorising of chastity and fidelity are connected to the exigencies of boundary maintenance, symbolised through notions of purity and honour. While

these restrictions affect upper caste women in more stringent ways, they constitute a generalised set of norms which serve as a reference point even if not practiced by all castes. Socialisation towards these and mechanisms of monitoring, control and punishment are vested in the family-household (Ganesh, 1998: 122). Thus for a woman in the Indian context the household itself becomes a place of control and threat. Even when they are suffering, the ways in which their distress is interpreted is mediated by the structures present in the society.

It was only recently that a gender-sensitive analysis, possibly the first of its kind in the country, of the data gathered in these epidemiological studies was made, which questioned the gender-biased assumptions of earlier research and highlighted the psychosocial stressors associated with women's position and roles in society. Drawing on the data gathered by epidemiological studies conducted in our country since the 1960s, Davar (1999) in her critique of these studies pointed out that despite their methodological shortcomings and politically misleading inferences, the data converged qualitatively on some significant dimensions of being a woman with mental distress in India. While no marked gender difference has been seen in the case of severe mental disorders that have a biological basis, women were found to be at least twice as frequently ill as men in the case of common mental disorders which have a psychosocial aetiology. Therefore, a bio-medical approach to women's mental health is inadequate, since a larger part of mental disorder epidemiology in women is constituted by the common mental disorders whose causes are located in psychosocial factors. This underscores the necessity of adopting a different and exclusive approach to women's mental health concerns. Common mental disorders appeared to provide a comfortable space within psychiatry for talking about distress that women faced rather than seeing their distress as 'illness behaviour'. Also gender differences occur particularly in the rates of common mental disorders—depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 3 people in the community and constitute a serious public health problem (WHO, 2008).

Economic and social policies that cause sudden, disruptive and severe changes to income, employment and social capital that cannot be controlled or avoided, significantly increase gender inequality and the rate of common mental disorders. Trends have shown that the migration of women has increased in the last decade because of increasing feminisation of labour. More women than men are said to suffer from mental disorders. And yet psychological distress of women has

not been articulated as a distinct agenda either by the academia or the women's movement in our country (Vindhya et al., 2001).

In order to contextualise the links between micro-processes and macro-processes, we are presenting a narrative of a woman living in an urban slum in Delhi. We have chosen to do this through a narrative as to understand any society or a part of society, it is important to discover its repertoire of legitimate stories and find out how it evolved (Czarniawska, 2004: 5). Using narrative approach is useful as an enacted narrative can be seen as the most typical form of social life (MacIntyre, 1990: 129). In this article, we are trying to understand the individual in a particular social context; therefore, it becomes important to bring out the 'legitimate stories' from that social space. Bela whose narrative is presented later had approached the researcher herself as she felt that her experience would be relevant to the researcher's work.

'We Did Something Wrong …'

I am around 55 years, I look Nepali but I am not (*smiled*) *I am a Sikh from a village in Rajasthan. The main difficulty in our life is our son. He started drinking; we don't even know what he drinks. He used to work as a driver used to stay separately; he had a love marriage. They used to be very happy—he was always buying things for her, suddenly they had some fight and they separated. After that he got into trouble—took something expensive, lost his job. So he came to live with us and then started stealing things from the house— watches. I felt very bad that my son had turned to this. He was once beaten up and left to die because he tried to steal someone's wallet. My son used to be handsome and earned well now he is skin and bones. We kept him in a home—he became okay for some time. But his wife stays nearby, he watches her go—she looks very nice, wears jeans; I don't know what he feels but he becomes very quiet.*

My husband is good; we were poor but that can be managed, now our problems started with children. Everyone used to say your children are very good, they speak nicely and are attractive but all of them are in trouble. I lost one girl to jaundice when she was one and a half year old. My other daughter has a good marriage, they were very nice people but her husband died suddenly. She discovered it one morning when she took tea for him. First time we ever saw anything like that. She went into a shock—used to sometimes laugh, sometimes cry. She was like a 'crazy' person, never cared about food. I took her to a government hospital but they made us run from one place to another and nothing happened. Finally we took her to another nursing home; I never took her for 'jhada', I don't believe in all this. When I have pain, I take a medicine

for 1–2 rupees. In the nursing home they did all the tests and told us that she had T.B. (*tuberculosis*). *Her stomach had swollen but she improved in a year. That was a tough time for me. We felt we had done something wrong with our children, while talking about this I feel sad and that is why it pains. I always have problems with stomach now. My husband is very ill, children just leave the medicines, he does not take it; he has no will to live anymore. He says what would happen to me Bela if you were not there. I force him to take medicine.*

We still feel that something we did was not okay; children are so different from us. My younger son wears clothes this length (pointing to her knee) cut jeans. When I say something, he says that you are old fashioned. He (youngest) wants a bike but left work at factory saying that pay was less and work is more. Instead of thinking of a bike he should work; they want things fast without working. I tell him earn at least 2000 that will help but they want to be like big people—new clothes, things without working hard for it.

My middle son brings CDs of old songs and we compare the meaningful lyrics of those days with the songs of today. Then life was much better now I don't understand it much.

In the following sections various aspects of Bela's narrative are explored further. Keeping her narrative as central we will also present the voices of other women in the field site. This will help in bringing out the similarities and differences (amongst women in the field site) in the way in which psychosocial distress is experienced, expressed and dealt with.

Mothering and Distress

Bela brought out the stress of mothering at the beginning of the narrative itself. This was not surprising as concept of 'mother' is not merely given in natural processes (pregnancy, birth, lactation, nurturance), but is a cultural construction which different cultures build up and elaborate in different ways (Moore, 1988: 25). In starting with her children's problems she was in part also verbalising the stress created on her, as she had not performed her assigned role well because of which her children were suffering. Her narrative contains multiple layers of distress and in multiple people. She started out with talking about her son's distress which arose because of his marital problems and the ways in which distress was expressed—increased drinking, losing his job, changes in him from being 'handsome to skin and bones', becoming quiet when he sees his wife. Poverty is not seen as a big issue by her but problems for family

members are the main sources of distress. Bela's sadness when she talks about how her children went from being the 'model children' to all of them having trouble in their lives is evident. The death of her daughter's husband, her subsequent illness also took a toll on her. Gilligan (1982) stated that in the case of women, the concept of identity expands to include the experience of interconnection. The moral domain is similarly enlarged by the inclusion of responsibility and care in relationships. Therefore, any difficulty faced by those in a woman's intimate circle usually has a strong corelation with her pain and distress. Bela then whose identity is woven into the identities of the family members and who considers herself as the main person responsible for her family's welfare feels like a failure because she is not able to understand her own children. In comparison to Bela who feels that she is not able 'to do much' for her children, Chanda (60 years) with five children brought out the pressures of doing 'too much'.

> *My elder son lives upstairs, he works but contributes nothing to the family income, he comes home drunk and spends all his money on that. I take care of both his daughters since his wife died. I have brought up all the children on my own. 25 years of bringing up the kids alone (3girls and 2 boys), my health is affected. I have pains and aches in my body but I don't worry about them. I am just tired now. My worries are almost never ending with four women in the house. Sons were the ones who wanted to pressurize me to name the property in their favour but I believe that I would be on the road if I did that. Till I die I will keep the property because this might ultimately help in the granddaughter's marriages—I have to worry about that as well. My boys are useless, elder daughter earns. When I die what will happen to granddaughters, in two years they will start looking very grown up. There is only one regret—two of my daughters did not get married.*

For 25 years Chanda has brought up her children as a single mother and at a time when there is an expectation of being looked after, she has found that she is still the main caregiver not only for her children but also her granddaughters. Dube (1986) argued that while popular notions of reproduction recognised the close bond between mother and child, the bonding became a context where maternal obligations were underlined, rather than one where the question of rights over offspring is addressed. While appearing to accord a place to the female role in conception, the emphasis on maternal duty in such a popular discourse sets limits to the mother–child bond and, consequently, offsets any possibility of a challenge to structural arrangements (ibid.). Bela and Chanda's situations are a reflection of the pressures which this kind of ideology puts on women.

Whether recommended by psychologists or elicited from ordinary people around the world, a 'good mother' promotes the well-being and development of her children and is almost always patient, protective, nurturing and generous (Barlow and Chapin, 2010: 326). In order to remain a 'good mother' an ageing Chanda still needs to protect and nurture children (specifically her sons); this continues although she feels that if not for the property in her name she would be thrown out by them. She continues to allow them to live in her house in spite of the problems they create. For Chanda, her mother had been the main support system after the death of her husband, *'My mother asked me to marry again but with five kids my family was too big, mother used to sell vegetables, she lived nearby, she taught me this work and I ran my family through this.'* Even after she had five children her mother continued to care for her and was instrumental in helping her resurrect her life by teaching her work skills. Therefore, the model of mothering in Chanda's mind was someone who continued to 'take care' of her children. Lines of thinking within psychological anthropology, some of them psychoanalytic, acknowledge that each mother brings to her mothering actions her own personal history and psychological dispositions. She is the product of her own lifetime of experiences and the sense she has made of them (Barlow and Chapin, 2010: 329). Chanda's experiences of being supported by her mother gives rise to 'all giving ever present' mother image in her; this disposes her to continue to shoulder the responsibility of her grown up children.

Another area of conflict and distress between women and their children is the area of 'aspirations'. Bela's description of feeling inadequate as a parent in spite of the efforts made by her and her husband who is unwell brings out this conflict clearly. She feels that they have been unsuccessful because their children are so different from them. This is emphasised in their relationship with their younger son who considers them to be old-fashioned. His want for things and money and refusal to keep working at a job which provides substantial help at home brings out the restlessness that is facing many young people today. With the global culture and trends coming into our lives with television and other media the changes have been very fast. The wish to have more is fuelled by the variety and the kinds of things that we see today (culture of aspiration). This wish to have more is accompanied by the lack of capacity to lead a certain lifestyle. Many parents are working hard to provide a lifestyle and not just the basics; whereas the son refuses to work at a low paid job and makes not much of an effort to find a new one either. This phenomenon witnessed in many urban poor households is increasing the burden on families especially the women, who consider it their duty to fulfil the

wishes of everyone. This change in aspirations was evident during festivals when everyone wants to buy new things, as one of the women stated '*Nayi cheezen kharidna aaj kal ke ideas hain*' (Buying new things are modern ideas). Usually this translates into less savings and households surviving on the edge; this has been recognised as the new face of poverty by the World Development Report 2000/01 as well, which exemplifies this by including risk and vulnerability as integral to the multi-dimensional understanding of poverty: 'poverty means more than inadequate consumption, education and health … it also means dreading the future—knowing that a crisis may descend at any time, not knowing how one will cope …. Poor people are often among the most vulnerable in society because they are most exposed to a wide array of risks.'

Maternal obligations of providing for the children included not only their basic needs but also needs that arose out of aspirations leading to psychosocial distress in women. This distress was usually expressed through the body. For example, Bela says, *'I always have stomach problems now'* and Chanda complains about aches, pains and tiredness in the body. Pain in different parts of the body especially in the stomach which is described as occurring often is something which came up in the narratives of many other women as well.

> *I am running the house on a daily basis. I have to take my son to the hospital as well, I have never travelled so much—at this age, and I have to take my adult son all over. So I can't sleep at night. My daughters also have to get married and I am very worried about that. At night I sit and think about my daughters, I have pain in my entire body and I hardly eat anymore.* (*Sanjeeda, 45-year-old women with five children and a husband who was unemployed*)

> *My mother has money but will my brothers give me and my children any money after she is gone? I keep thinking about this all day. I am always having headaches—I can't sleep at night—I feel uneasy* (*ghabrahat hoti hai*). *I sit and watch TV or keep thinking these thoughts again and again till 2–3 in the night and then get up at 5 in the morning. My health is going down.* (*Zayeeda, 20-year-old woman with two children who has been abandoned by her husband*)

In most of the narratives everyday distress is expressed metaphorically through the body. The body represents the experience of social world as felt by the women. In a study by Patel et al. (2007) the commonest category of symptoms reported by women in Goa were aches and pains, most commonly pain in the limbs and joints and headache. The next

common category of symptoms was autonomic symptoms. More than half the participants complained of palpitations. Social and cultural attitudes and struggles are played out in the terrain of the individual body. The individual body and its sicknesses are not so much representations of the larger environment as a vital and inseparable part of it (Coker, 2004: 17). In her research with the southern Sudanese refugees in Cairo, she found that they spoke about pain being everywhere and also nowhere at the same time. It is found in the heart, the stomach, the head and the legs but particularly in the 'self' (ibid.: 17). Similarly, for the women in the field site, distress is lived out through the pain in their bodies. Embodiment of distress has implications in the way it is addressed.

Bela believes in taking only allopathic medicine and says that when she has pain, she pops a pill. But while explaining her pain, the explanation is clearly psycho-social—yeh bat karte hue gam hota hai, isliye dard hota hai (I feel sad while talking about this, that is why it pains). For her pain in the stomach is an expression of distress but the way she deals with it is to take a 'pill'. Many other women in the field site came up with similar views:

> *My health has also gone—my body hurts—limbs hurt. I am having some medicines but all my tests were done and nothing came out. The doctor says that I take too much tension because of which I keep having the pains.* (*Kamala, 50-year-old woman who feels burdened with household work and financial worries*)

> *My back is always paining; doctor once said thyroid test but everything was normal. I think it's after my operation for the last child; it was in private. I have too much anxiety that is why I cannot sleep well* (*Tension to mujhe bahut hoti hain isliye main ache se so nahi pati*). (*Sita Devi, 40-year-old woman struggling with managing a household of six on a single income and fighting to ensure admission to a school for one of her daughters*)

Pain in different parts of the body is indicative of the social suffering of the women in the field site. The struggles in their everyday life are embodied and expressed as pains and aches. Categories of distress are borrowed from each other, compressing idioms which although hybrid, aim to convey shared meanings and similar life experiences. The principle underlying this analogical reasoning is one in which similar life circumstances are seen as producing a similar illness among people (Eskell-Blolkland, 2009). Kielmann (2002) suggests that the body is not merely a site of suffering but the space and medium through which one can articulate the experience of the self. Symptoms such as white

discharge as 'idioms of distress' in India (Nichter, 1981) or 'heart distress', chest pains and palpitations in Iran (Good, 1977) demonstrate how culture shapes illness and how emotional distress is expressed through the physical body (Trollope-Kumar, 2001).

Conclusion

In the analysis of the narratives; we have brought out psychological as well as socio-cultural arguments for explaining women's distress, this is because these explanations are complementary and not contradictory. Social and psychological factors combine to create a complicated web of reality. As Bourdieu (1992) states that correspondence between social and mental structures fulfils crucial political functions as symbolic systems are instruments of knowledge as well as instruments of domination. Therefore, these systems influence the way people think about themselves and their surroundings. The link between social and cognitive structures provides one of the most solid props of social domination. Bela's narrative then brings out many different themes which affect her mental health—difficulties in the lives of her children, poor health of husband, increasing demands of her younger son, her problems when she tries to seek treatment for her daughter within the hospital set-up. All these immediate difficulties are increasing the vulnerability of her household. In addition to that, larger structures present in the society are in some ways creating and sustaining these difficulties. The narratives of other women intersecting with Bela's narrative bring out the manner in which social conditions as symbolic systems create certain mental structures in women; for example, what it takes to be a good mother. Strauss and Quinn (1997: 113) argue that there is a significant tendency for the content of what is taught to be reproduced over successive generations. Also some motivations are deliberately inculcated by socialisers (p. 105). They emphasise that people come to want to perform certain behaviours, even apart from explicitly taught to behave that way, is from social evaluations of particular others who matter to us, whether our elders or our peers.. their approval and disapproval, with all the strong emotions engendered by these, make us want to what those important to us care about being and want us to be, which accounts for much conformity to dictates of our family, our peer group and other groups to which we belong (ibid.). Whether women are able to fulfil this 'ideal' often determines the level of distress they face in their everyday lives. Not being able to meet this ideal 'mental structure of a good mother' often leads to

psychosocial distress amongst women which is then expressed in the form of bodily pain.

Mothering is only one of the reasons of distress, the narratives of women bring out many other issues which create distress in women—health and education of other family members, financial worries, changing aspirations of youth as well as dealing with multiple household responsibilities. Some of these issues are related to the macro level changes in economy and policy. The psychosocial distress faced by women is not just related to individual issues but has its roots in the rapidly changing social conditions as well.

This article has brought out different ways of understanding mental health and mental illness. The intersections among urbanisation, mental health and gender emphasise the need to move away from a purely biomedical perspective to one which is broader and reflects the true reality. Mental health is not just rooted in one individual but is affected by the micro and macro forces surrounding the person, such as changing aspirations related to consumer goods, educational attainment and so on. This is clearly brought out through the literature presented and the subsequent narratives. Giving a diagnosis of depression or dysthymia to a person in Bela's position would be akin to symbolic violence which then legitimises the social order based on inequality. Although not unique to the urban environment, social stress is concentrated in urban contexts. It may arise because of factors like high population density, lack of traditional social networks, degraded family structure, inadequate housing and insufficient privacy. Social stress may arise because of the necessity to manage numerous 'selves' or social roles (Goffman, 1959). Not only there are more people to deal with in a given time, there are more types of people (professions, social relationships and economic relationships) with whom to interact. This may be more necessary in the human heterogeneity of urban settings than in rural settings (ibid.).

The extent of changes that have come about through globalisation which offered everyone a brighter future does not seem to have culminated into reality as it seems to have created social systems which are more inequitable. Although, we are not sure how good the old world was; it seems to be the only outlet available for a woman from a poor urban household whose forays into nostalgia through old songs make her believe and long for the old world as she seems unable to deal with or comprehend this 'new world'.

Note

1. 'That is why it pains'.

References

Aday, L. (2001). *At risk in America.* San Francisco: Jossey- Bass Publishers.

Almeida-Filho, N., Lessa, I., Magalhães, L., Araújo, M.J., Aquino, E., James, S.A., & Kawachi, I. (2004). Social inequality and depressive disorders in Bahia, Brazil: Interactions of gender, ethnicity, and social class. *Social Science and Medicine, 59*(7), 1339–1353.

Appadurai, A. (2004). The capacity to aspire: culture and the terms of recognition. In V. Rao, & M. Walton (Eds), *Culture and public action* (pp. 59–84). Delhi: Permanent Black.

Arun, S. (1999). Does land ownership make a difference? Women's roles in agriculture in Kerala, India. *Gender and Development, 7*(3), 19–27.

Barlow, K. & Chapin, B. (2010).The Practice of mothering: An introduction. *Ethos, 38*(4), 324–338.

Blue, I. (1999). Intra-urban differentials in mental health in Sao Paulo, Brazil. *PhD thesis*. London: South Bank University.

Blue, I. (2001). Urban inequalities in mental health: The case of Sao Paulo, Brazil. In D. Matcha (Ed), *Readings in Medical Sociology* (pp. 217–224). Boston: Allyn and Bacon.

Bourdieu, P. (1988[1984]). *Homo Academicus.* Cambridge: Polity Press

Bourdieu, P., & Wacquant, L. (1992). *An invitation to reflexive sociology.* Cambridge : Polity Press.

Chossudovsky, M. (1994). *The globalisation of poverty: Impacts of IMF and World Bank reforms.* Penang, MY: Zed Books.

Coker, E. (2004). Travelling pains: Embodied metaphors of suffering among Southern Sudanese Refugees in Cairo. *Culture, Medicine and Psychiatry, 28* (1), 15–39.

Czarniawska, B. (2004). *Narratives in social science research.* New Delhi: SAGE Publications.

Davar, B. (1999). *Mental health of Indian women: A feminist agenda.* New Delhi: SAGE Publications.

Deshpande, A. (2002). Asset versus autonomy? The changing face of the gender - Caste overlap in India. *Feminist Economics, 8*(2), 19–35.

Doyal, L. (1995). *What makes women sick: Gender and the political economy of health.* London: MacMillan.

Dube, L. (1986). Seed and earth. In L. Dube (Ed.), *Visibility and power: Essays on women in society and development* (pp. 22–53). Delhi: Oxford University Press.

Elson, D. (1994). Structural adjustment with gender awareness. *Indian Journal of Gender Studies, 1*(2), 149–167.

Eskell-Blockland, L. (2009). Listening to oral traditions in a re-searching for Praxis in a Non-Western context. *Journal of Health Management*, *11*(2), 355–373.

Ganesh, K. (1998). Gender and kinship studies: Indian material and context. In C. Risseeuw, & K. Ganesh (Eds), *Negotiation and social space: A gendered*

analysis of changing kin and security networks in South Asia (pp. 113–133). New Delhi: SAGE Publications.

Gilligan, C. (1982). *In a different voice: Psychological theory and women's development.* Cambridge, MA: Harvard University Press.

Goffman, E. (1959). *The presentation of self in everyday life.* New York: Anchor.

Good, B. J. (1977). The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine and Psychiatry*, *1*(1), 25–58.

Harris, O. (1981). Households as Natural Units. In K. Young, C. Wolkowitz, & M. McCullagh (Eds), *Of Marriage and the market: Women's subordination in international perspective* (pp. 203–225). London: CSE Books.

Kakar, S. (1982). *Shamans, mystics and doctors.* New Delhi: Oxford University Press.

Karlekar, M. (2005). Breaking the Silence. In M. Khullar & I. Taehakyyo (Eds), *Writing the women's movement* (pp. 300–324). New Delhi: Zubaan.

Kielman, K. (2002, July 18–19). Gender, well-being and quality of life. *Paper presented at Gender, Health and Politics Workshop in South Asia, 2002, sponsored by the South Asia Institute and the Department of Tropical Hygiene and Public Health*. Heidelberg: University of Heidelberg.

Kleinman, A. (1987). Anthropology and psychiatry: The role of culture in cross-cultural research on illness. *British Journal of Psychiatry*, *151*(4), 447–454.

MacIntyre, Alasdair (1981/1990). *After Virtue*. London: Duckworth.

Moore, H. (1988). *Feminism and Anthropology.* Cambridge: Polity Press.

Nguyen, V., & Peschard, K. (2003). Anthropology, inequality and disease: A review. *Annual Review Anthropology*, *32*, 447–474.

Nichter, M. (1981). Idioms of distress: Alternatives in the expression of psycho-social distress: A case study from south India. *Culture, Medicine and Psychiatry*, *5*(4), 379–408.

Obeysekere, G. (1985). Depression, Buddhism and the work of culture in Sri Lanka. In A. Kleinman & B. Good (Eds), *Culture and Depression* (pp. 134–152). Berkeley: University of California Press.

Obeysekere, G. (1990). Culturally constituted defenses and the theory of collective motivation in personality and the cultural construction of society. In D. Jordan, & M. Swartz (Eds), *Papers in hounour of Melford E. Spiro* (pp. 80–97). Tuscaloosa and London: University of Alabama Press.

Parker, S., Fernandes, J., & Weiss, M. (2003). Contextualizing mental health: Gendered experiences in a Mumbai slum. *Anthropology and Medicine*, *10*(3), 291–308.

Patel, V. (2001). Cultural factors and international epidemiology. *British Medical Bulletin*, *57*(1), 33–45.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., & van Ommeren, M. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet, 370*(9591), 991–1005. doi:10.1016/S0140-6736(07)61240-9

Patel, V., Araya, R., Lima, M., Ludermir, A., & Todd, C. (1999). Women, poverty and common mental disorders in four restructuring societies. *Social Science and Medicine*, *49*(11), 1461–1471.

Rodman, M. (1992). Empowering place: Multilocality and multivocality. *American Anthropologist, 94*(3), 640–656.

Schell, L. (1997). Culture as a stressor: A revised model of biocultural interaction. *American Journal of Physical Anthropology*, *102*(1), 67–77.

Strauss, C., &and Quinn, N. (1997). *A cognitive theory of cultural meaning*. United Kingdom: Cambridge University Press, United Kingdom.

Thapan, M. (2006). Habitus, performance and women's experience: Understanding embodiment and identity in everyday life. In R. Lardinois, & M. Thapan (Eds), *Reading Pierre Bourdieu* (pp. 199–228). New Delhi: Routledge.

Trivedi, J., Sareen, H., & Dhyani, M. (2008). Rapid urbanization—Its impact on mental health: A South Asian perspective. *Indian Journal of Psychiatry, 50*(3), 161–165.

Trollope-Kumar, K. (2001). Cultural and biomedical meanings of the complaint of leucorrhea in South Asian women. *Tropical Medicine and International Health*, *6*(4), 260–266.

United Nations Population Division. (2002). *World Population Prospects: The 2000 Revision.* New York: United Nations.

Vindhya, U., Kiranmayi, A., & Vijayalakshmi, V. (2001). Women in psychological distress: Evidence from a hospital based study. *Economic and Political Weekly, 36*(43), 4081–4087.

World Health Organization (1998). *The World Health Report: Executive Summary.* Geneva: World Health Organization.

World Health Organization (Department of Mental Health and Substance Abuse) (2008). *Gender Disparities in Mental Health*. Geneva: WHO.

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