



International Journal of Humanities & Social Science Studies (IJHSSS)

A Peer-Reviewed Bi-monthly Bi-lingual Research Journal

ISSN: 2349-6959 (Online), ISSN: 2349-6711 (Print)

ISJN: A4372-3142 (Online) ISJN: A4372-3143 (Print)

Volume-X, Issue-VI, November 2024, Page No.94-102

Published by Scholar Publications, Karimganj, Assam, India, 788711

Website: <http://www.ijhsss.com>

DOI: 10.29032/ijhsss.v10.i6.009

Mental Health and Gender Roles: Differences of Gender in the Perception of Mental Health in India's Working-Class Population

Abanti Bhattacharya

Assistant Professor, Department of Psychology, Government General Degree College, Singur, West Bengal, India

Received: 30.09.2024; Accepted: 18.10.2024; Available online: 30.11.2024

©2024 The Author(s). Published by Scholar Publication. This is an open access article under the CC BY license (<https://creativecommons.org/licenses/by/4.0/>)

Abstract:

This article analyses the gendered differences in the perception of mental health within India's working-class population, with a focus on how socio-cultural factors and gender roles shape mental health outcomes. The article examines how poverty, lack of access to healthcare, and social isolation exacerbate mental health challenges for women in low-income settings. Women, particularly those who have experienced adverse reproductive outcomes, report higher levels of mental distress than men. These disparities are rooted in societal expectations that position men as stoic providers and women as primary caregivers, leading to varying experiences of mental health issues. Furthermore, Gender disparities are prominently observed in the prevalence of common mental disorders (CMDs), with women exhibiting higher rates, particularly in conditions such as depression, anxiety, and somatic complaints. Access to mental health care presents a substantial challenge for India's working-class population, with gender serving as a crucial determinant in shaping this access. The article emphasizes the need to challenge traditional gender norms and improve access to gender-sensitive mental health services in India's working-class communities.

Keywords: Gender Differences, Mental Health, Working-Class, Reproductive Health, Socio-Cultural Factors.

Introduction: The discourse on mental health in India has undergone a transformative shift in recent years, but it remains fraught with cultural, social, and economic constraints. Nowhere is this more evident than in the working-class population, where mental health challenges intersect with issues of poverty, education, and employment. Within this

demographic structure, the perception of mental health often diverges along gender lines. These divergences are deeply embedded in India's patriarchal structure, wherein gender roles and expectations significantly influence how mental health issues are understood, experienced, and addressed. In this context, examining the gendered differences in mental health perception within the working-class population in India provides insight into broader social inequalities and cultural dynamics. This article seeks to explore the ways in which gender shapes the perception of mental health in India's working-class population, highlighting the social determinants that underlie these differences and offering a critical analysis of the barriers to mental health care for both men and women.

The Socio-Cultural Framework of Mental Health in India: In India, mental health has traditionally been a stigmatized issue, often overshadowed by concerns about physical health. This is particularly true in the working-class population, where access to healthcare is limited and mental health is not prioritized. The socio-cultural framework in India continues to uphold gender-specific expectations: men are seen as providers, expected to maintain stoicism in the face of adversity, while women are assigned the role of caregivers, whose emotional labour is often invisible or devalued. These entrenched gender roles shape not only the experience of mental health challenges but also the way such challenges are perceived by individuals and society at large. For working-class men, mental health issues are often perceived as a threat to their masculinity. The expectation to be the primary breadwinner places immense pressure on men to exhibit emotional resilience, often leading them to suppress feelings of anxiety, depression, or stress. Admitting to mental health problems is frequently viewed as a sign of weakness, which is incompatible with traditional notions of masculinity. In contrast, working-class women often face the "double burden" of paid work and unpaid domestic labour, which places them at greater risk for mental health issues such as depression and anxiety. However, women's mental health concerns are frequently dismissed or attributed to "natural" emotional reactions, rather than being recognized as legitimate psychological issues requiring attention and care.

Examining India's Gender Gap in Mental Health: Insights from Psychological Case Studies: Research consistently shows that women tend to report lower levels of mental well-being compared to men (Davar, 1999; Kessler, 2006; Patel, Araya, de Lima, Ludermitz, & Todd, 1999; World Health Organization, 2009). In recent years, there has been growing interest in the connection between women's mental and reproductive health, with reproductive health issues increasingly recognized as having a significant impact on their overall health and quality of life (Patel, 2005; Patel & Ooman, 1999; World Health Organization, 2009). Although these studies have provided valuable insights into how social and economic factors intersect with reproductive and mental health, much of the existing research focuses on wealthier nations. According to the World Health Organization (2009) report, most studies in this field have been conducted in countries such as Australia, Canada, the USA, and Europe. Alarming, only about 10 percent of research on the link between maternal mental health and child health comes from low- and middle-income

countries. This means that mental health issues in resource-poor areas remain significantly understudied.

This article engages with three major strands of scholarship within the broader discourse on mental health and gender. Firstly, much of the current research is concentrated in nations with well-established medical systems where maternal and child mortality, as well as maternal morbidity rates, are relatively low. This focus has left significant gaps in understanding the complex links between reproductive and mental health in low-resource settings. The World Health Organization (2009) notes that in developing countries, where pregnancy loss is more common, the emotional impact of miscarriage may be heightened, particularly in societies where a woman's identity is strongly tied to motherhood (WHO, 2009). However, this claim remains largely speculative, lacking empirical data. Anthropological studies on reproductive failure in impoverished families with high child mortality rates suggest a more layered picture. Maternal grief can be shaped by cultural interpretations of pregnancy loss and reproductive health (Cecil, 1996; Pinto, 2008; Ramasubban & Singh, 2001). In some cases, mothers might focus their emotional energy on children perceived to have a better chance of survival, while those viewed as frail may not receive the same level of attachment (Scheper-Hughes, 1993). These nuances emphasize the need for research that is more context-specific in low-resource settings.

Secondly, the prevailing medical approach in public health, which tends to view women as isolated individuals and reduces the body to a site of disease (Foucault, 1973), has led to an oversimplified understanding of the mental health impact of reproductive events. Most studies have limited their focus to specific conditions, such as pregnancy loss or menopause, treating them as standalone events affecting mental health (WHO, 2009). However, adopting a life-course perspective allows for a more comprehensive view, considering how reproductive experiences are interconnected with broader household dynamics, such as family illness or economic challenges (Batra, 2003; Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). As the World Mental Health Report (WHO, 2001) asserts, mental health should not be viewed simply as a set of symptoms but rather as a cluster of adversities and disabilities that shape individuals' ability to care for themselves and their families (Desjarlais, Eisenberg, Good, & Kleinman, 1996).

Quantitative approaches alone often fall short in capturing the intricate connections between various factors affecting mental health. Murray and Lopez (1998) highlight the challenge of measuring "dependent co-disability," where one type of disability—whether physical or social—heightens the risk of another. This suggests a need to broaden research methods to include qualitative approaches, such as analysing personal narratives. These methods provide deeper insights into the complex interplay of poverty, reproductive challenges, and mental health that shape individuals' real-life experiences in these intertwined situations.

Moreover, it is crucial to recognize the unconscious bias that arises when we focus solely on how a woman's poor mental health affects her ability to care for others. This narrow

view reinforces the stereotype that women are the primary caregivers while ignoring other important factors (Boyce, Hickey, & Parker, 1991). We need to broaden our perspective to consider how women's capabilities are also influenced by the behaviours and attitudes of those around them—whether it be male partners, extended family, co-workers, or societal expectations that force women into rigid gender roles (Kittay, 1998). For instance, studies show that young women in low-income areas who find employment may face an increased risk of violence, as this can be seen as challenging male authority. However, it is unclear whether older women face similar risks (Krishnan et al., 2010).

In 2001, the Institute of Socio-Economic Research on Democracy and Development (ISERDD) launched a long-term study of urban households across seven neighborhoods in Delhi, including poor, middle-income, and affluent areas. Household expenses (reported in 2002 Indian Rupees, \$1 = Rs. 49.09) ranged from Rs. 4,165 to Rs. 16,117 in these areas, and households were randomly selected after initial contacts were made. The study revealed that, consistent with global patterns, women reported higher levels of mental distress than men. Data from 789 adults, mainly spouses, collected between 2001 and 2003, showed that education, household spending, and age did not explain the gender disparity. However, women who experienced adverse reproductive outcomes, particularly child loss, reported significantly higher distress. When these factors were accounted for, the gender gap in mental health decreased. Additionally, the study found a strong connection between mental and physical health for both men and women, with no significant differences in how these factors impacted each gender (Das et al., 2012).

Gender Differences in the Context of Common Mental Disorders: Gender disparities are especially prominent in the occurrence of common mental disorders (CMDs), such as depression, anxiety, and somatic complaints, where women are more frequently affected. Unipolar depression, which is expected to become the second leading cause of global disability by 2020, is found to be twice as common in women as in men. Similarly, women are two to three times more likely than men to experience anxiety disorders like generalized anxiety disorder (Pattison, 2002). Notably, depression is not only widespread among women, but it also tends to be more persistent than in men (WHO, 2000). While depressive symptoms are generally similar across genders, women often exhibit atypical symptoms, such as increased appetite and weight gain. In the case of anxiety disorders, women face more severe symptoms, higher rates of co-occurring depression, and a more complex course of illness (Pattison, 2002). Studies from India align with global trends, showing that CMDs, including depression and anxiety, are strongly associated with female gender and poverty. Both community studies and clinical research suggest that women are two to three times more likely to suffer from these disorders (Thara & Patel, 2001). This raises an important question: why are women more vulnerable to CMDs?

Hormonal fluctuations related to reproductive cycles may partially explain women's increased susceptibility to depression (Parry, 2000). However, gender-related disadvantages also play a critical role in elevating their risk. Factors such as alcohol abuse by partners, domestic violence, widowhood or separation, limited decision-making power, and lack of

family support are closely tied to higher rates of CMDs in women (Shidhaye & Patel, 2010; Nayak et al., 2010). Additionally, stressful life events are strongly linked to the onset of depression, especially in vulnerable individuals. Throughout their lives, women are confronted with numerous stressors, including childbirth, caregiving duties, and looking after elderly or sick relatives. Women also often face disempowerment due to limited educational and employment opportunities. Even women with financial security may be hesitant to challenge social norms, leaving them equally susceptible to mental health issues.

Male Perceptions of Mental Health amidst Working Class Populace: In India's working-class context, men are often the primary earners, facing significant financial pressures to support their families. This creates a societal expectation that men should remain stoic and resilient, regardless of their emotional state. As a result, many men in these communities tend to downplay or entirely dismiss mental health issues, perceiving them as non-existent or irrelevant to their lives. This reluctance is compounded by stigmatization: discussing mental health problems is often seen as a threat to their masculinity, leading men to adopt a hypermasculine posture of emotional invulnerability. Studies show that working-class men are less likely than their female counterparts to seek professional help for mental health issues, often resorting to substance abuse, such as alcohol consumption, as a coping mechanism.

Several explanations grounded in the concept of masculinity have been put forward to explain men's reluctance to seek help. One prominent perspective centers around hegemonic masculinities, which suggest that men gain privilege and power by embodying traits such as emotional control, self-reliance, and toughness. In this framework, refusing help is seen as a way for men to reinforce their power and masculinity (Bunton & Crawshaw, 2002; Courtenay, 2000). This idea is supported by substantial evidence, with numerous studies showing that masculinity, particularly when expressed through emotional restraint and self-reliance, is associated with lower levels of help-seeking and more negative attitudes toward seeking assistance (Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016).

The Precarious Manhood model sheds light on why men often hesitate to seek help for conditions like depression. According to this model, manhood is seen as a fragile social status that requires constant maintenance and is easily threatened (Bosson & Vandello, 2011; Bosson, Vandello, Burnaford, Weaver, & Wasti, 2009; Vandello & Bosson, 2013). Being depressed or showing sadness can be perceived as a loss of power, leading men to avoid behaviors that might make them seem vulnerable. Men feel pressured to continually prove their masculinity through public displays, remaining acutely aware of any behaviors that could undermine their status (Bosson & Vandello, 2011). Recent studies support this view, revealing that men experience greater distress and fear of losing their gender identity when faced with psychological conditions like depression and anxiety, which are not typically associated with masculinity. In contrast, externalizing disorders such as aggression and substance abuse align more with traditional male stereotypes (Michniewicz, Bosson, Lenex, & Chen, 2016). Consequently, men are more likely to endure their emotional struggles in silence rather than seek help, as doing so could be viewed as unmanly

(Vandello & Bosson, 2013). This reluctance to seek help contributes to the stigma surrounding men's mental health, reinforcing negative attitudes toward psychological support (Lindinger-Sternart, 2015). Research further confirms that higher levels of self-stigma are linked to more negative attitudes toward help-seeking in men (Galdas, Cheater, & Marshall, 2005; Vogel, Wester, Wei, & Boysen, 2005).

Social Determinants of Mental Health in the Working-Class Population: The social determinants of mental health—such as income, education, employment, and social support—play a significant role in shaping the mental health experiences of India's working-class population. For both men and women, economic insecurity is a primary source of stress, but the impact of this insecurity is mediated by gender. Men, as primary earners, face immense pressure to provide for their families. In working-class households, where income is often unstable and jobs are precarious, this pressure can lead to high levels of stress, anxiety, and depression. However, the stigma surrounding mental health in men prevents many from seeking help, leading to a cycle of unaddressed mental health problems and harmful coping strategies. For women, the lack of economic independence exacerbates mental health issues. Many working-class women are financially dependent on their husbands or male relatives, which limits their access to mental health care. Additionally, women's mental health is often overlooked in favour of their physical health or the needs of their families. Social isolation, domestic violence, and gender-based discrimination further compound the mental health challenges faced by women in India's working-class population.

Access to Mental Health Care: Access to mental health care remains a significant challenge for India's working-class population, and gender plays a critical role in shaping this access. While mental health services are limited overall, women face particular barriers in seeking care. Gender norms often restrict women's mobility and autonomy, making it difficult for them to access mental health services without the approval or support of male family members. In many cases, women's mental health issues are dismissed as less important than the needs of their families, leading to a lack of timely intervention and care. For men, the barriers to accessing mental health care are more psychological and social. The stigma surrounding mental health in men, particularly in working-class communities, prevents many from seeking help. Even when services are available, men may avoid them due to fear of being perceived as weak or incapable of fulfilling their roles as providers. This reluctance is further compounded by a lack of awareness about mental health and available resources. In recent years, there has been a growing recognition of the need for gender-sensitive mental health services in India. However, these services remain largely inaccessible to the working-class population due to economic, social, and cultural barriers. Efforts to improve mental health care must take into account the unique challenges faced by men and women in this demographic and work to dismantle the gender norms that perpetuate stigma and silence around mental health issues.

Conclusion: The perception of mental health in India's working-class population is deeply shaped by gender roles and societal expectations. While men are expected to exhibit

emotional strength and resilience, women are often burdened with the dual responsibilities of work and caregiving, leading to significant differences in how mental health issues are understood and addressed. These gendered perceptions of mental health contribute to disparities in access to care and treatment, with both men and women facing unique challenges in seeking help for mental health problems. To address these disparities, it is essential to challenge the cultural norms that perpetuate stigma around mental health and to expand access to gender-sensitive mental health services. By promoting greater awareness and understanding of mental health issues in working-class communities, and by ensuring that mental health care is accessible and appropriate for both men and women, India can begin to address the mental health needs of its working-class population in a more equitable and effective way.

References:

- 1) Batra, A. (2003). Burn mortality: recent trends and socio-economic determinants. *Burns*, 29, 270-275.
- 2) Bosson J. K., Vandello J. A. (2011). Precarious manhood and its links to action and aggression. *Current Directions in Psychological Science*, 20, 82–86.
- 3) Bosson J. K., Vandello J. A. (2011). Precarious manhood and its links to action and aggression. *Current Directions in Psychological Science*, 20, 82–86.
- 4) Bosson J. K., Vandello J. A., Burnaford R. M., Weaver J. R., Wasti S. A. (2009). Precarious manhood and displays of physical aggression. *Personality and Social Psychology Bulletin*, 35, 625–634.
- 5) Boyce, P., Hickey, I., & Parker, G. (1991). Parents, partners or personality? Risk factors in postnatal depression. *Journal of Affective Disorders*, 21, 245-255.
- 6) Bunton R., Crawshaw P. (2002). Risk, ritual and ambivalence in men's lifestyle magazines. In Henderson E. S., Petersen A. (Eds.), *The commodification of health care* (pp. 187–203). London: Routledge.
- 7) Cecil, R. (1996). *The anthropology of pregnancy loss: Comparative studies in miscarriage, stillbirth, and neonatal death*. Oxford: Berg.
- 8) Courtenay W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, 50, 1385–1401.
- 9) Das, J., Das, R. K., & Das, V. (2012). The mental health gender-gap in urban India: patterns and narratives. *Social Science & Medicine*, 75(9), 1660-1672.

- 10) Davar, B. V. (1999). *Mental health of women in India: A feminist agenda*. New Delhi, India: Sage Publications.
- 11) Desjarlais, R., Eisenberg, L., Good, B., & Kleinman, A. (1996). *World mental health report*. New York: Oxford University Press.
- 12) Foucault, M. (1973). *The birth of the clinic: An archeology of medical perception*. New York: Pantheon Books.
- 13) Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: literature review. *Journal of advanced nursing*, 49(6), 616-623.
- 14) Kessler, R. C. (2006). The epidemiology of depression among women. In C. L. M. Keyes, & S. H. Goodman (Eds.), *Women and depression: A handbook for the social, behavioural, and biomedical sciences* (pp. 22-37). Cambridge, Massachusetts: Cambridge University Press.
- 15) Kessler, R. C., McGonagle, K. A., Swartz, M., Blazer, D. G., & Nelson, C. B. (1993). Sex and depression in the national comorbidity survey I: lifetime prevalence, chronicity, and recurrence. *Journal of Affective Disorders*, 29, 85-96.
- 16) Kittay, E. F. (1998). *Love's labor: Essays on women, equality, and dependency*. London: Routledge.
- 17) Krishnan, S., Rocca, C. H., Hubbard, A. E., Subbiah, K., Edmeades, J., & Padian, N. S. (2010). Do changes in spousal employment status lead to domestic violence? Insights from a prospective study in Bangalore, India. *Social Science & Medicine*, 70(1), 136-143.
- 18) Lindinger-Sternart S. (2015). Help-seeking behaviors of men for mental health and the impact of diverse cultural backgrounds. *International Journal of Social Science Studies*, 3, 1-6.
- 19) Michniewicz K. S., Bosson J. K., Lenex J. G., Chen J. I. (2016). Gender-atypical mental illness as male gender threat. *American Journal of Men's Health*, 10, 306-317.
- 20) Murray, C. J. L., & Lopez, A. D. (1998). Health dimensions of sex and reproduction. *Global Burden of Health and Injury Series*, 111, Harvard School of Public Health, Boston.
- 21) Nayak, M. B., Patel, V., Bond, J. C., & Greenfield, T. K. (2010). Partner alcohol use, violence, and women's mental health: population-based survey in India. *The British journal of psychiatry*, 196(3), 192-199.
- 22) Parry, B.L. (2000). Hormonal basis of mood disorders in women. In Frank E, editor. *Gender and Its Effects on Psychopathology*. Washington DC: American Psychiatric Press; pp. 61-84.
- 23) Patel, V. (2005). *Gender in mental health research*. Geneva: World Health Organization.
- 24) Patel, V., & Ooman, N. M. (1999). Mental health matters too: gynecological, morbidity and depression in South Asia. *Reproductive Health Matters*, 7, 30-38.

- 25) Patel, V., Araya, R., de Lima, M., Ludermir, A., & Todd, C. (1999). Women, poverty and common mental disorders in larger restructuring societies. *Social Science & Medicine*, 49(11), 1461-1471.
- 26) Patel, V., Kirkwood, B. R., Pednekar, S., Pereira, B., Barros, P., Fernandes, J. & Mabey, D. (2006). Gender disadvantage and reproductive health risk factors for common mental disorders in women: a community survey in India. *Archives of general psychiatry*, 63(4), 404-413.
- 27) Pattison, H. (2002). Women's mental health: a comprehensive textbook. *BMJ*, 325(7358), 285.
- 28) Pinto, S. (2008). *Where there is no midwife: Birth and loss in rural India*. New York: Berghahn Books.
- 29) Ramasubban, R., & Singh, B. (2001). Weakness ("Ashaktapanna") and reproductive health among women in a slum population in Mumbai, India. In C. M. Obermeyer (Ed.), *Cultural perspectives in reproductive health* (pp. 14-34). New York: Oxford University Press.
- 30) Scheper-Hughes, N. (1993). *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.
- 31) Seidler Z. E., Dawes A. J., Rice S. M., Oliffe J. L., Dhillon H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, 49, 106–118.
- 32) Shidhaye, R., & Patel, V. (2010). Association of socio-economic, gender and health factors with common mental disorders in women: a population-based study of 5703 married rural women in India. *International journal of epidemiology*, 39(6), 1510-1521.
- 33) Thara, R., & Patel, V. (2001). Women's and mental health. *Regional health forum* (Vol. 5, pp. 24-34).
- 34) Vandello J. A., Bosson J. K. (2013). Hard won and easily lost: Review and synthesis of theory and research on precarious manhood. *Psychology of Men & Masculinity*, 14(2), 101–113.
- 35) Vogel D. L., Wester S. R., Wei M., Boysen G. A. (2005). The role of outcome expectations and attitudes on decisions to seek professional help. *Journal of Counseling Psychology*, 52, 459–470.
- 36) World Health Organization. (2000). *Women's mental health: An evidence-based review*.
- 37) World Health Organization. (2001). *The world health report 2001-Mental health: New understanding*, New Hope. Geneva: World Health Organization.
- 38) World Health Organization. (2009). *Mental health aspects of women's reproductive health: A global review of the literature*. Geneva: World Health Organization.