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# "A woman's life is tension": A gendered analysis of women's distress in poor urban India

**Saloni Atal**[1] and **Juliet Foster**[2]

**Abstract**

The mental health of women living in poverty is a growing public health concern, particularly in India where the burden of illness is compounded by critical shortages in mental health providers and fragmented services. This was an exploratory study which sought to examine low-income women's perceptions of mental illness and its management in the context of urban poverty in India. This research was prompted by the lack of empirical studies documenting how women in marginalized sections of society understand mental illness. Data were collected through a combination of 10 focus group discussions and two individual interviews with a total of 63 women residing in low-income areas of Mumbai. Social representations theory was used to explore shared meanings of mental illness among women in this setting. Thematic analysis of the data showed that women use the expression "tension" to talk about mental illness. Tension was described both as an ordinary part of life and a condition having its origins in more profound gender-related stressors, particularly pressures surrounding motherhood, chronic poverty and domestic conflict. Approaches to managing tension were pluralistic and focused on the resumption of social roles. Findings are consistent with other studies in similar cultural contexts, suggesting a shared, transnational character to women's distress and the need for scholarship on women's mental health in low-income settings to be more attuned to gendered forms of marginalization.

**Keywords**

gender, idioms of distress, India, resilience, South Asia, women's mental health

## Introduction

The mental health of women in the poorest parts of the world has gained attention as a major global public health challenge with the rise of the Movement for Global Mental Health (MGMH henceforth). This movement is interested in scaling up mental health care for low-income populations through the expansion of mental health services in primary care settings and by popularizing strategies such as task-shifting, in which clinical tasks are performed by non-specialized mental health workers due to the shortage of specialists (Patel et al., 2011). The present study is part of our response to the growing interest in the mental health of women in the poorest parts of the world. Our study was conducted in India and aims to document how slum-dwelling women experience and explain their mental health problems. Given the value placed on biomedical frameworks in programs of research and intervention promoted by the MGMH (Jain & Orr, 2016), we were interested in the extent to which women subscribed to a medical model, how their understandings relate to their particular sociocultural context, and how they approached the issue of managing their mental health.

### *Women's mental health in slums*

In the city of Mumbai in India, over 40% of households live in slums or other resource-poor settings characterized by overcrowding, insecure residential status, inadequate water access, and inadequate sanitation access (Chandramouli, 2011). While urbanization

[1]Primary Care Unit, Institute of Public Health, University of Cambridge
[2]Institute of Psychiatry, Psychology and Neuroscience, King's College London

**Corresponding author:**
Saloni Atal, Primary Care Unit, Institute of Public Health, Cambridge CB2 3BC, UK.
Email: ssa46@cam.ac.uk

provides many social and economic opportunities, research suggests that the urban poor face a number of stressors that can take a toll on their mental health (Subbaraman et al., 2014). To meet their financial needs, the majority of slum-dwelling women work, but they typically have limited job choices and heavy workloads (Kotwal et al., 2008).

Global mental health studies suggest that poor women may face multiple pathways to disadvantage that cumulatively and differentially affect their mental health. Women are more likely to be victims of violence in their homes; emotional, physical, and/or sexual abuse is estimated to be nearly 40% among married women in India (Malhotra & Shah, 2015). Women who experience such violence are far more likely to suffer from depression and alcohol use and to attempt suicide (Nayak et al., 2010). Cultural norms surrounding marriage and male child preference also precipitate distress among women. Studies on low-income mothers show that they are at greater risk for developing postnatal depression if they fail to give birth to sons (Pereira et al., 2007). Deliberate self-harm among women has also been linked to harassment due to Dowry-related practices where the bride's family is expected to provide gifts or money to the groom's family before marriage (Parkar et al., 2012). Such data demonstrate that the pathways linking gender, poverty, and mental health are complex and that this nexus needs to be further investigated (Kruger & Lourens, 2016).

### *Perspectives of lay women*

Women's health problems have traditionally been defined by expert discourses, and feminist scholars have objected to the absence of perspectives from the women themselves (Ussher, 2010). We see a similar absence of women's voices in the emerging literature on global mental health. Critical global mental health scholars have raised questions surrounding the cultural relevance of biomedical discourses that are informing the work of this movement. Some have argued that a privileging of biomedical frameworks is problematic in non-Western cultures, where local explanatory models may not reflect dominant Western paradigms (Summerfield, 2012). Others suggest that an exclusively biomedical discourse depoliticizes the issue of mental health and detracts attention away from the need to create supportive social contexts (Burgess & Campbell, 2014). Against the backdrop of such critiques, there has been increasing interest in cultural meaning-making systems and articulations of distress (e.g., Jain & Orr, 2016).

In the present study, we add a gendered dimension to these culturally focused critiques. We argue that expressions of distress are not only cultural, but are also gendered and must be analyzed through intersectional frameworks. Although there are a few qualitative studies in the Indian context examining how poor women make meaning around mental illness, these are limited to women seeking treatment in the formal mental health care system (e.g., Kermode et al., 2007; Pereira et al., 2007). These studies also look at women's representations only instrumentally in terms of their resonance with existing diagnostic categories. A few notable exceptions are Parkar et al.'s (2003, 2012) research on the gendered effects of slum life and Snell- Rood's (2015) anthropological work on relational and psychological coping strategies used by Indian women living in slums.

### *Theoretical framework*

Social Representations Theory (SRT henceforth) is grounded in a consideration of the ways in which social groups communally make meaning out of the concepts with which they come into contact, and how these representations constitute their social realities. Social representations have specific functions: they provide groups with ways of understanding and making sense of issues and phenomena that surround them, as well as ways of communicating about them (Moscovici, 1984).

SRT was employed in this study for several reasons: Firstly, SRT stresses different forms rather than hierarchies of knowledge and has traditionally been used by researchers to "give voice" to socially disenfranchised groups (Zadeh, 2017). There is a strong tradition of work using SRT in the area of mental illness where lay knowledges have occupied a subjugated position (e.g., Foster, 2003, 2006; Morant, 2006). Secondly, where other theories of public knowledge and attitudes have been accused of failing to adequately address the "social" in meaning-making systems held by individuals, an SRT perspective, dialogically oriented as it is, provides greater sociological awareness and access to social meaning (Moscovici, 1963). This theoretical openness is particularly important in the present research given that one of our fundamental concerns is the relationship between representations and gendered forms of power.

This article extends knowledge on women's mental health in low-income contexts in three key ways: Firstly, in foregrounding women's own perspectives on mental illness, our analytical approach marks a departure from the bulk of contemporary work on gender and mental health in India, which has traditionally been concerned with prevalence rates of mental illness and evaluations of prevention and treatment programs. Secondly, we take an interest in

understanding how women's representations of mental health relate to the broader social contexts that they inhabit. Thirdly, in focusing our study on a non-clinical sample of women, we aim to highlight endogenous resources used by women with a view to supporting efforts aimed at prevention and community capacity-building.

## Methods

### Study sites and sample

India scores poorly on measures of gender equality (Kishor & Gupta, 2009) and makes for an important case study for gendered dimensions of distress (Patel, 2005). We focus specifically on the city of Mumbai because it houses a large agglomeration of low-income urban areas (Parkar et al., 2003). A total of 63 respondents between the ages of 18 and 55 years currently residing in low-income areas of Mumbai were interviewed. Fifty of our respondents were recruited in partnership with three non-governmental organizations (NGOs) involved with empowering women through skill building. An additional 13 women working as housemaids were recruited through the first author's own community networks. The main characteristics of the sample are presented in Table 1. The number of women to be interviewed was determined iteratively using the criterion of saturation that originates from grounded theory methodology (Guest et al., 2006). The participants who were included in the study came from different professions and also represent different ethnic and religious groups. While the sample is not random, the range of women included adds some degree of analytical generalisability (Miles & Huberman, 1994).

### Data collection

The data were collected by the first author in 2015 and 2016 through 10 focus group discussions (FGDs) and two individual interviews. The first author is female, and we believe this facilitated a gendered connection or what sociologists call a "short term contract"—providing participants the necessary freedom to share and reveal details of their lives (Hey, 2003). FGDs were selected as the primary method for data collection to replicate conditions under which respondents would normally communicate and therefore produce insight into their socially shared frameworks for understanding and talking about mental illness (Farr, 1993).

The two individual interviews were conducted with women who volunteered to describe their personal experiences of mental ill health in greater detail. The first author decided to interview them individually to protect them from stigma and also because it was not practical for them to provide detailed personal accounts in a group format. The discussions with them proceeded in the style of an episodic interview to facilitate depth of inquiry (Flick, 2000). The FGDs focused on participants' responses to a vignette describing the fictionalized case of a woman experiencing psychological and behavioral symptoms of distress (e.g., insomnia, social withdrawal, and appetite loss). The vignette was designed with reference to previous studies on mental health perceptions in the region (Wagner et al., 1999) and piloted for clarity and cultural relevance (see Appendix A). The vignettes did not mention the names of any mental illnesses, and during the discussion participants were asked to consider questions such as "Is this a mental health problem?", "What do you call it?", "What kind of care or support does this person need?", "What care is available in your community?", and "What should be done for this person?" A vignette-based interview methodology was considered appropriate keeping in mind the stigma attached to mental illness in India and also that participants were mostly illiterate. FGDs lasted between 40 and 60 minutes on average. They took place in quiet and relatively private locations in the community (such as inside participants' homes, in the local temple, or at the NGO center), and these locations were chosen by respondents themselves. All discussions were recorded in Hindi using a digital voice recorder.

### Data analysis

The recorded discussions were transcribed verbatim into Hindi and then translated into English by the first author and another bi-lingual speaker to facilitate

**Table 1.** Background characteristics of respondents.

| Group | Profession | Age range | Religion | Marital status | Sample size |
|---|---|---|---|---|---|
| NGO A | Unemployed (slum-dwelling) | 18–55 years | Hindu, Christian, and Muslim | All married with children | 28 |
| NGO B | Beauticians and tailors | 18–28 years | Hindu and Muslim | Unmarried | 13 |
| NGO C | Sanitary napkin manufacturing | 20–50 years | Muslim | Some married with children | 9 |
| Non-NGO D | Housemaids | 30–50 years | Hindu and Christian | All married with children | 13 |

cross validation. In the process of translation, special attention was paid to conceptual equivalence, rather than mere line-by-line translation (Temple & Young, 2004). The data were coded through a partially inductive and partially deductive framework. In the deductive stage, the first author read through all of the transcripts and coded the data for segments of text using NVivo software 10. Codes were organized into thematic categories following Braun and Clarke's (2006) method. Themes were defined as: "something about the data that is important in relation to the research question and represents some level of patterned response or meaning within the data set" (Braun and Clarke, 2006, p. 82). While the identified themes are supported by a number of instances, no quantifiable criterion, such as repetition, was used. A data audit was performed to establish consensus between the first and second authors on the allocation of coded transcript material to thematic categories. Communicative validation was employed, and efforts were maintained at all stages of the study to ensure coherence and consistency, and also to ensure the researcher's own representations were taken into consideration (Duveen & Lloyd, 1993).

### Ethical approval

The study was approved by the Psychology Research Ethics Committee at the University of Cambridge. Informed consent was sought from each individual participant who provided verbal or written consent prior to participation in the group discussions or individual interviews. Participants were assured of their right to withdraw from the interview process at any time and that their decision about whether to participate would not have any bearing on their relationship with the NGO. All information provided by respondents was kept confidential from the NGO in concern, aside from cases where NGO representatives were present during the group discussions (relevant for respondents from groups A and B). An NGO representative was present in these cases to guide the researcher into the relevant community location, but only participated minimally in discussions and did not observe or evaluate the participants in any way.

## Results

In their responses to the fictionalized character, study participants differentiated between two forms of mental affliction: tension and *pagalpan* (madness). These were described as varying in their severity and causes. Salient aspects of the representation are discussed in the following sections, with illustrative quotations.

### Tension

*Causes of tension.* All women interviewed in the study used the English word "tension" in their responses to the fictionalized character in the vignette. Tension was used by respondents to describe a wide range of worries and concerns in their own lives, from everyday hassles to more profound and chronic sources of distress. Thematic analysis of women's descriptions identified three interrelated causal categories: family relationships, social roles, and poverty.

Family relationships. Respondents highlighted a number of challenging dimensions of family life that contribute to their tension. Those in our sample who were married spoke about the tension caused by alcoholic, unsupportive, and absent husbands and the associated lack of companionship and financial support. This is illustrated in the following quotation where a respondent describes the distress of a friend:

> Her husband for 15 years has not gone to work. Her name is Megha. She has three children. She has to take care of her mother-in-law. Eating is difficult for her. She works from morning till evening . . . there is a lot of tension. So on her own alone what will she do, take care of school, of her house, her rent, everything. Sometimes her children are also sick. Then what will she do. (Group A)

For younger and unmarried respondents, tension was associated with the death of family members and loved ones. Although insecurities around economic dependency were implicit in their accounts, the primary concern for them was the sudden shock and inability to manage their grief. This can be gauged in the following anecdote, where one of our respondents narrates the case of a young girl she knew who experienced unmanageable tension following her mother's death:

> She was a very nice and pretty girl, not more than 16 or 17 years old. Suddenly, her mother died. The trauma of the incident had really gone to her head and she went mad. She started behaving like a child, asking people for laddoos [an Indian sweet]. Such was the effect of the trauma . . . She could not even recognize people anymore. (Group B)

All our respondents also reported being distressed by intergenerational conflicts with siblings, parents, and in-laws. These disagreements were described as occurring primarily due to financial matters such as disputes over land ownership and pressures arising from having to send remittances to their villages:

> I have been feeling very very bad. My head was hurting so much last week that I fainted for a few hours. It was because I have been having a lot of tension lately. My husband's family in our village keeps asking us for money, you see. There is so much family and money tension. (Group D)

Social roles. Respondents across the sample alluded to tension associated with fulfilling social roles in highly precarious circumstances. Married respondents lamented the loss of autonomy after marriage and a number of them spoke of conflicts with their mothers-in law due to expectations surrounding how they should behave as "good wives" within their new family unit: "Once you are married, you are under the care of your husband and his family. If for some reason they are not good to you, then life is hard and there is tension" (Group A).

Unequal gender norms were so central to their representations that tension was ultimately seen as being inseparable from the texture of a woman's life in this setting. This sentiment is evocatively expressed by one of our respondents in the following statement: "Didi [sister], a woman's life is tension" (Group D).

Younger respondents in the study discussed coercive marital norms as contributing intensely to their tension. In the following quote, a respondent speaks of the costs to young girls like her of indulging in romantic relationships or even simply engaging with non-kin males: "Our society is very judgmental about how we speak to men, whether we go to their houses or get too close to them. I personally do not look beyond my work and my home" (Group B).

Poverty. The experience of poverty was salient in women's accounts of tension. This was particularly the case for mothers in our study, who frequently discussed the tension associated with being a "good mother" within a context of extreme poverty. In her narrative below, one of our respondents demonstrates that her distress is not due to her own hunger, but due to the agony of being unable to feed her children:

> When our kids are small, we have a lot of tension. We have to support them entirely because they are too young to work and earn for the family ... Sometimes when things are bad and I can't feed my children, I start feeling helpless; there is just too much tension. (Group D)

*Managing tension.* Although respondents in our study used tension generically to refer to varied sources of stress in their everyday lives, they also saw it as a potentially serious illness. A number of respondents highlighted the somatic and psychological symptoms associated with tension, which included insomnia, lack of appetite, palpitations, and a racing heart:

> Tension causes you to feel weak and sick. When you have tension, you can become very tired. Your head hurts. You keep thinking about the things in your life that are going wrong. In the process, you may stop eating properly as well. (Group A)

In their efforts to manage tension, women relied on their own psychological and social resources and did not see it as necessary to seek professional help. Advice seeking and unburdening through sharing with friends and kin were most frequently discussed as strategies to alleviate tension:

> My friend Manju is like my doctor and I share everything with her to feel lighter. That is all you need when you have tension. You just have to feel loved and find someone to talk to and then all of it comes out of your system like dirty water. (Group D)

Several respondents emphasized the importance of thinking positively and actively reframing their life situations: "Thinking positively is vital. If today is bad, tomorrow will be better. That is how I see life. Start every day anew" (Group D);

> Every person has to create his or her own wajood [character]. As a woman, I feel that I have to fight for myself, through a thousand happinesses and sadnesses ... I have to work to educate my children. It is only with this kind of "can do" attitude that we can make progress. (Group D)

The workplace was also discussed as a source of distraction from domestic tensions by respondents who were in some form of employment:

> Whenever I come here in the morning, before we start our work, we always talk to each other and share everything that has happened to us. This takes away all our tension. When we go back home, we have a fresh mind. (Group C)

Although these might appear to be positive coping strategies, for many respondents they were shaped by expectations that women "manage" their problems. This was especially the case for mothers in the study, who viewed any form of self-care as self-indulgence. In this sense, while women did indeed "manage" on their own, it was at a cost to themselves: "As a mother, we

have to put our kids before our own feelings and make a serious effort to move forward in life" (Group A).

A number of respondents also emphasized the benefits of drawing on group-based support networks, such as *mahila mandals* (women's groups) and church groups. In the following account, a respondent speaks of her reliance on religious faith as a means of coping with economic insecurity and family conflict:

> Sometimes I do question the purpose of my life. It can be very stressful when we are facing financial problems and I have to deal with all of her [sister-in-law] oddities. But we are Christians and I believe very strongly in the power of prayer. Meeting others at Church helps me to get relief and manage all of these problems. (Group D)

Less commonly, women sought advice from medical doctors. The decision to see a doctor was determined both by the nature of the women's financial situation and the severity of their physical symptoms: "The amount of discomfort you are experiencing will determine whether or not you make the decision to go and see the doctor. If you can bear it, then you just bear it by yourself" (Group A); "We always have to think about whether or not we have the money to go and see a doctor. Going to the doctor is only worth it when you are in pain" (Group A).

## Pagalpan *(madness)*

Madness was represented as an extreme or abnormal form of tension. Madness was differentiated from tension through its associations with threatening, bizarre, and socially inappropriate behaviors, such as talking to oneself, showing aggression, and dressing inappropriately. In this sense, "mad" persons were perceived as having an experience that is qualitatively different from those experiencing tension:

> I feel scared just by looking at these mad people because they behave in abnormal ways. I cannot understand them at all. I would not take the initiative to talk to someone who is mad. But with a person in tension, I will be more naturally inclined to help them. (Group B)

Madness was described by respondents as having its origins both in psychological and social factors. The internalization of tension due to rumination and lack of social support was the most common cause of madness in their accounts: "It is largely because of the ways in which people think that they go mad. When you take too much tension, you start behaving in strange ways" (Group C); "If you don't share your feelings with others, the tension keeps on brimming within you. Eventually, it becomes poisonous and causes you to go mad" (Group C).

Themes of loss and abandonment in the context of romantic relationships also featured centrally in women's explanations. In the following narrative, one of our respondents attributes the odd behavior of her sister-in-law to heartbreak in her youth: "I think she behaves in this way because she is not married. In her younger days she may have been in love with some fellow and it did not end well. That's why she is mentally off" (Group A).

Although most spoke of "madness" in stigmatizing ways, respondents who were younger and more educated took a critical stance and questioned the validity of the label "mad." They were also sympathetic to the plight of the "mentally ill" and expressed concerns around their subjective distress, loneliness, and isolation:

> Personally, I think no one is really mad. If you tell people they are mad, they will start believing it, even if it is not true, and eventually they become like passive recipients … We can really torture people with these labels and unnecessarily harm them. (Group C)

> Everyone calls her mad and other insulting names. But, when she comes to work here, we treat her like one of us and do not see her as a "mad person." We don't want to be like everyone else in society. We want to show more love and compassion because that is the only way to get the best out of people. (Group C)

Respondents were generally skeptical of whether medical doctors alone could help with tackling the problem of madness, and emphasized the need for both medicine and prayer (*dava our dua*). *Babas* (a Hindi term used loosely by respondents to refer to religious and faith healers) were described by respondents as being capable of restoring inner harmony in ways that medical doctors cannot: "I think that when a person goes mad, they need to find a way to calm their mind. Medicines cannot do this but the *baba*, a good *baba*, can" (Group A); "Just as a doctor has medical knowledge, the *baba* has spiritual knowledge and also experiential knowledge. Based on this knowledge, they give us advice which can help us change the way we see things" (Group A).

However, across sociodemographic categories, respondents also questioned the credibility of *babas* and viewed any kind of engagement with them as taboo. Several respondents provided anecdotes of negative experiences that they (or others known to them) had had with *babas*:

> In my village, there was a girl who was not well. They went to take her to the *baba*. The *baba* took her to a

closed room. Then he started touching her, holding her hair, and putting his hands all over her body . . . I don't believe in these *babas*. Unmarried and sleazy men who take advantage of young and impressionable girls—that is what they are. (Group A)

## Discussion and conclusion

In this study, we were interested in examining how women residing in poor urban communities in India talk about their psychological distress. The findings presented above suggest that women's representations of mental illness are mediated by broader representations surrounding the performance of womanhood under conditions of severe poverty. Across group discussions, respondents said that the character presented in the vignette was experiencing "tension" and that this was a relatively normal response to stressors in her life. Respondents did not generally think that the character in the vignette was afflicted by a mental illness. They equated mental illness with "madness," and described it as a serious psychological state that results from experiencing too much tension or from internalizing tension. Madness was associated with danger, difference, and more negative social consequences.

The distinctions that respondents in our study made between tension and madness resemble lay understandings of mental illness in Western cultural contexts, where scholars have found that neuroses are represented as less Other than psychoses (e.g., Foster, 2006). It is important to recognize here that there were ambivalent forms of Otherness in women's representations of tension, or what Moscovici called cognitive polyphasia (Moscovici, 1984). While the term tension was used in relatively non-stigmatizing ways and was discussed by respondents as an ordinary part of their lives, there was also recognition of its pathological character and potential to lead to more serious forms of illness.

From a social representations perspective, such polyphony makes good sense and is a reminder that representations serve social functions (Wagner et al., 1999). It may be the case that being part of a women's organization sets up a social representational challenge for respondents: how do they accept the notion of "mental illness" when folk theories and personal experiences leave them with a sense of fear? Perhaps, as Wagner and Kronberger (2001) suggest, polyphasic representations provide knowledge resources that women can draw on in different social contexts. On the one hand, rejecting traditional anchors of "otherness" and displaying greater tolerance toward the notion of mental illness enables them to claim solidarity with the groups they are part of. On the other, a coexisting sense of fear allows them to maintain distance from the mentally ill in their own personal space (Renedo & Jovchelovitch, 2007).

The use of the English word "tension" to describe non-clinical mental distress by the respondents in our study when a Hindi equivalent (i.e., *tanav*) exists suggests that it carries social and cultural meaning. We take a feminist reading of our data and argue that "tension" is used by respondents as a metaphor for their sense of powerlessness in the face of gendered oppressions. The quotations presented above provide a number of examples where respondents directly attribute their tension to inescapable conditions of poverty. For many respondents, tension also has its origins in pressures to conform to normative expectations surrounding femininity, womanhood, and marriage. To conflate tension with psychiatric illness would in our view be akin to medicalizing social problems, such as poverty, food insecurity, and gender inequality.

The term tension has been reported in a number of other studies examining how specific expressions of distress are used by Indian women (e.g., Halliburton, 2005; Pereira et al., 2007; Rashid, 2007; Rodrigues et al., 2003; Snell-Rood, 2015). Weaver (2017), for instance, almost identically finds that middle-aged women in urban North India attach the label of tension to various stresses of modern urban life, including low levels of empowerment, poverty, spousal violence, family conflicts, sexual violence, and feelings of uncontrollability. Some scholars argue that tension represents a distinct cultural syndrome and that it is an illness in and of itself (Karasz et al., 2013). Although few studies have taken tension as their object of inquiry, Weaver's research (Weaver, 2015; Weaver et al., 2017) on Indian women with diabetes finds that tension does not map neatly onto depression or anxiety (as measured by the Hopkins Symptoms Checklist-25) and instead includes elements of both.

Similar associations between motherhood, poverty, and mental health have also been reported in studies looking at precipitators of distress among women in other cultural contexts. Kruger and Lourens (2016), for instance, have found that women implicate the challenges of good mothering under destitution and especially the hunger of their children in their accounts of depression. Burgess and Campbell (2014), similarly, find that HIV/AIDS affected women stress poverty, cultural norms surrounding marriage, unemployment, and intergenerational conflicts when talking about their mental well-being. In the medical anthropology literature, a number of scholars have written of the "idioms of distress" (Nichter, 2010) that poor women use to speak of their psychosocial health problems in the face of economic hardship and inability to effect structural change in their lives. Rashid's (2007) study of

Bangladeshi women, for instance, explores how the nonspecific complaint of white vaginal discharge (i.e., *safed pani* in Hindi) connects with profound sources of distress in their lives.

In his seminal work, Nichter (2010) argued that idioms of distress are important as culturally appropriate forms of expressing stigmatized experiential states. We extend Nichter's argument in this article to say that idioms of distress are not only cultural, but are also gendered, and should be examined in relation to gendered forms of disadvantage and vulnerability. Feminist scholars have long taken the stand that "the personal is political." That women transnationally use idioms of distress to implicate structural disadvantage in their daily lives is revealing of the affective dimensions of uneven development and globalization in the lives of women in the Global South (Chua, 2012).

We conclude this article with two practical implications of our findings for enriching scholarship on women's mental health in poor countries. Firstly, respondents in our study understand mental illness in essentially social terms through the idiom of tension. Tension is directly tied to the material conditions of their lives and misogynistic norms that govern their behavior in the private and public sphere. They take a pragmatic and pluralistic approach to managing their mental health, placing emphasis on fulfilling gender roles rather than on accessing medical experts. Representations held by this social group are at odds with approaches currently being taken toward treatment and prevention. India's National Mental Health Programme (NMHP) as it currently stands places emphasis on enhancing accessibility to mental health care through transformations within the health system. While in theory the NMHP is meant to be integrative and holistic, studies show that in practice the dolling out of pharmaceuticals is prioritized over psychosocial aspects of treatment, and communities are seen as little more than the geographical setting in which interventions take place (Jain & Jadhav, 2009). Health system-based reform is of obvious importance in a large and diverse country such as India, but our data clearly suggest that there is a parallel need to address the social and ecological factors that are perpetuating women's suffering. This may require activities outside the formal health sector that are aimed at community empowerment and social development (Raja et al., 2012).

Secondly, "tension" appears to be a socially acceptable expression by which women in this setting communicate their suffering. Taking gendered dimensions of tension into account could have implications for mental health promotion in these communities, and also for designing culturally valid screening tools. There have been some efforts to develop scales to measure tension in India (e.g., Karasz et al., 2013; Weaver et al., 2015), but additional research is needed to validate their broader use. Following Kaiser et al. (2015), we suggest that taking idioms such as tension into account also has the potential to enhance social and communicative aspects of health exchange despite the construct's lack of diagnostic specificity. Although our study has focused on women's understandings of tension, we would advocate that future studies examine the ways that men experience and talk about tension as well. It is not clear from the literature whether the use of this idiom is restricted to women in South Asia. Comparative studies could provide a more rounded understanding of the significance of this idiom of distress.

In this study, we have demonstrated the importance of documenting women's own accounts of mental health. By drawing upon SRT, our study has extended insight into the social roots of women's psychological problems and implications for global mental health policy and practice. Our data suggest the need for greater sociological reflexivity in programs of research and intervention. Importantly, we also argue that theoretical frameworks need to move beyond cultural narratives to examine how expressions of distress in these settings relate to gendered forms of disadvantage. Attempts at supporting women must recognize and work with the concepts they hold and the social factors that frame their distress.

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## ORCID iD

Saloni Atal https://orcid.org/0000-0001-8814-9907

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**Saloni Atal**, MPhil, is a PhD student and a Gates scholar at the Institute of Public Health at the University of Cambridge. Saloni is a social psychologist researching social, cultural, and political factors that influence women's psychosocial well-being, voice, agency, and development in marginalized settings in South Asia. Her research takes an interdisciplinary approach, drawing on sociocultural theories of knowledge, critical development studies, postcolonial studies, and transnational feminist perspectives.

**Juliet Foster**, MA MSc PhD, AFBPsS, is Dean of Education at the Institute of Psychiatry, Psychology and Neuroscience at King's College London, and a social psychologist. Dr. Foster researches understandings of mental health problems, drawing on sociocultural theories of shared knowledge. She has published on understandings of mental health problems amongst the public as well as amongst people with lived experience, and has a particular interest in how these understandings develop and change, operating at a conscious and non-conscious level.

## Appendix A

### *Vignette*

(Note: Image of fictional character has not been included in this section, to avoid copyright infringement.)

Savita is 38 years old and a mother of three. She works as a cleaner in a school. Savita was fine until six months ago, when she started to complain of body aches and a general feeling of tiredness. She is unable to sleep at night. She also feels sad most of the time and has lost interest in her life. Even her children and family do not make her happy anymore. Savita has stopped going to work and is very worried about financial problems and managing her children.

### *Interview questions*

- What do you think Savita is experiencing?
- Why do you think she is experiencing these symptoms?
- Do you know anyone that has had a similar experience, and can you think of a specific case or instance?
- Do you think that some people in your community are more or less likely to experience these kinds of symptoms?
- What would you do if a member of your family or someone else you know experienced these symptoms?
- How would you help them?
- Are there any resources in your community that you would use?
- Would you take them to a traditional healer, a doctor, or to anyone else? If so, what do you think this person would do?