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ORIGINAL PAPER

Gender inequality and structural violence among depressed women in South India

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Abstract
Purpose While exploring experiences of psychological distress among psychiatric outpatients in Southern India, we set out to further understand interpersonal and socio-cultural factors that are associated with depressive symptoms.
Methods Using a grounded theory framework, we thematically coded narrative accounts of the women who sought treatment at the psychiatric clinic. In addition, we included author notes from participant observation and field work experiences in the South Indian psychiatric clinic.
Results Of the 32 women who participated in the study, 75 % qualified for a diagnosis of a current major depressive episode. Depressive symptoms were associated with experiences of domestic violence and, in Farmer's terms, structural violence. Although only a partial response to gender-based suffering, allopathic psychiatric treatment seemed the best available means of coping with their circumstances.
Conclusion The paper moves beyond a medicalized model of disease and behavior to explore social and contextual factors that enabled these women to brave additional stigmas surrounding psychiatric treatment and seek a better outcome for themselves. It concludes by discussing the need for a multi-layered approach to addressing the suffering that women in South India experience.

Keywords Gender · Inequality · Stigma · Structural violence · Depression

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Introduction

Studies of depressive disorders in India have described somatic presentations of distress, particularly among women [1–3]. The term "somatization" has been defined as the physical expression of psychological distress [4]. Other studies on depressive disorders in India weigh in on perceived causes, or explanatory models, of illness, attempting to understand the illness from the point of view of those who suffer from depression. In one such study, Pereira and colleagues [1] point out that women, although seeking treatment for physical or reproductive treatments, often identify familial relationships as the cause of their symptoms. This congruence between physical complaints and interpersonal causes becomes clearer when one understands that, consistent with Ayurvedic tradition, Indian ethno-medicine and philosophy do not subscribe to a Cartesian dualism that sees mind and body as distinct [5]. Ayurveda views the physical body as a crystallization of mental processes and the mind as a storehouse of interpersonal impressions that are accessed through the physical senses [6]. Thus, presentations of distress that are physical, but have interpersonal associations, are consistent with ethno-cultural representations in India.

Interpersonal factors associated with depression appear to be considerable for women in India. Emerging lines of research have begun to connect depressive symptoms

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experienced by women in India with intimate partner violence, partner alcoholism, and psychological trauma [1, 7–10]. In addition, alcohol abuse among Indian men has then been connected with intimate partner violence, subsequent trauma, and depressive symptoms among these victimized women [10]. Furthermore, studies in high-income countries have shown that depressive symptoms are a common response to experiences of intimate partner and gender-based violence [11–13].

Laws against domestic violence do exist in India [14]. However, a survey of social demographic research shows that rates of violence against women in India remain quite high: a recent National Family Health Survey reported the rate of women who experienced domestic violence in India at 35 % [15]. Another study reported that 2 % of all deaths in India were 'fire related' (e.g., suicides, kitchen accidents, and domestic violence), and that 37 % of these deaths occurred in young women between the ages of 15 and 34 [16]. Acts of domestic violence against women in India take various forms: beatings, rape, burning, acid attacks, and selective female infanticide [17]. These negative interpersonal experiences are set within a socio-cultural context in which women hold a lower status within society. For example, dowry is expected from the bride's family and patterns of patrilineal inheritance are common [17].

Socio-cultural influences on depression

Culture plays a central role in shaping emotional experience both within and outside of the individual [18]. Through culture, individuals learn different ways of expressing affect that are adaptable, acceptable, and functional in their families and communities. Culture provides the metaphors, concepts, and language that patients use to reflect upon and describe their experiences. Differences in value systems across cultures can also influence the expression of emotional distress. For instance, stigma is considered a universal occurrence with locally distinct aspects, dependent upon moral codes and power structures embedded within cultures [19, 20]. Link and Phelan [21] have stated that society's power differentials enable and perpetuate stigma. In this way, stigma aligns with *structural violence*, which Farmer and colleagues [22] have defined as "social structures—economic, political, legal, religious, and cultural—that stop individuals, groups, and societies from reaching their full potential, p. 1686".

Sen [23, 24] has described such social inequalities and 'unfreedoms,' and posited that unfreedoms occur profoundly among the poor. He argued that poverty should be seen as capability deprivation, observing its far-reaching impacts on factors such as an individual's social capital, their ability to earn an income, their self-esteem, and ability to pursue education [23, 24]. Further, poverty and its associated stigma and capability deprivation may affect the lives of women in countries like India more than men. Sen's analysis demonstrates that from childhood, women in India are more likely to suffer neglect with respect to nutrition and healthcare, which has impacts on morbidity, mortality, and overall well-being [23].

The ancient Hindu Laws of Manu state that women are never independent; they are to be protected by their fathers when young, their husbands when married, and their sons in old age [25]. Even with modernization and social changes spreading quickly through India, these traditional views seemed to hold powerful sway in many segments of south Indian society. For example, in many communities, a dowry, wealth paid to a prospective husband's family, is still expected at the time of arranged marriage in India. While officially, the practice of demanding dowry wealth is illegal, in practice, the law is rarely enforced. As a result, parents of daughters often worry about how they will save enough for dowries in order to have their daughters married and settled, and this worry begins when a daughter is first born. Daughters are sometimes seen as a burden, and their health and well-being become neglected throughout their lives [17] Clearly, power structures, embodied partly by laws and policies that are not enforced, are organized in such a way that women's' agencies are restricted.

With respect to depression, the research points to a connection between social status (lower social status, or stigma, associated with being a woman and poor) and depressive symptoms. One study connected the internalization of socially defined gender roles to the emergence of depressive symptoms in women, mediated by the constructs of shame and self-esteem [26]. Another study found a strong relationship between depression and poverty, and as well, a strong association between depression and female gender in South India [27]. Similarly, another large study, which pooled data from India, Brazil, Chile, and Zimbabwe found strong relationships between common mental disorders (including depression), poverty, and female gender [28]. Taken together, this line of work has begun to explore the important associations between poverty, female gender, and poor mental health.

The present study

The purpose of the present study was to further understand interpersonal and socio-cultural factors that are associated with depressive symptoms among women seeking treatment at a South Indian psychiatric clinic. Using an ethnographic approach, structured interviews, and analysis of field notes and participant narrative data, we explored the dynamics that influenced women to seek treatment for depressive symptoms.

Methods

Setting

The first author (D.R.) spent a year interviewing and observing patients and healthcare workers at the National Institute of Mental Health and Neurosciences (NIMHANS) in Bangalore, Karnataka State, in south India. Bangalore is the fifth-largest city in India, and due to globalization of information technology industries, it is the fastest growing metropolitan area in India. While this growth has raised the standard of living for many in Bangalore, the poor continue to struggle, and women disproportionately lack access to basic education. The overall literacy rate in Karnataka is 67 %, with male literacy at 76 % and female literacy at 57 % [29]. The majority of NIMHANS patients come from the rural and urban areas surrounding the city of Bangalore, and smaller numbers of NIMHANS patients travel from other states in India [30].

Sources

During a 1-year period of fieldwork, D.R. rotated with staff psychiatrists and residents in inpatient facilities and outpatient clinics, observing treatment practices. Sources for this report include field notes from these observations, notes from informal interviews with NIMHANS staff and trainees, and formal ethnographic and structured interviews with patients in the clinic. Treatment discussions between patients and physicians took place primarily in the local Kannada language, and conversations among physicians took place in English. D.R. is fluent in the Kannada language, and thus she conducted formal interviews with participants in Kannada. The interview instruments, described below, had been used in prior studies [3] and had been translation-back translated to ensure the original meanings of the instruments were preserved in Kannada.

We used the Explanatory Model Interview Catalogue for Affected Persons–Abridged (EMIC: [31]), which served as a formal ethnographic interview. The EMIC is a family of instruments that function as ethnographic interviews, providing a semi-structured method of understanding illness from the patient's point of view and yielding rich, narrative data that places the patient within a social context [32]. Items of the EMIC were subdivided into four sections, and contained open-ended questions that elicited narrative data about participants' health concerns (Patterns of Distress section), past treatment experiences (Help Seeking section), perceived causes/explanatory models of illness (Perceived Causes section), and the stigma they perceived or experienced (Stigma section). Examples of questions on the EMIC Patterns of Distress section, analyzed for this report, were "What has been troubling you?", "What do you call your problem?", and "Among all the concerns you have given, which one troubles you most?" Examples of questions from the Stigma section, also analyzed for this report, were "Have you ever been made to feel ashamed or embarrassed about your problem?" and "If they knew about your problem, would your neighbors, colleagues, or members of your community think less of you because of this problem?"

Participants were also interviewed with the Structured Clinical Interview for the DSM IV (SCID: [33]) to track the "etic", or allopathic constructs of illness. The SCID is a structured interview that is used primarily by researchers and clinicians for identifying symptomatology and diagnosing Axis I disorders. Csordas and colleagues [32] discussed the SCID's benefit in yielding some narrative data, although the data is centered upon the person's experiences around illness within the context of the body.

Procedures

D.R. integrated into the 'screening block' and 'follow-up clinic' at NIMHANS. In both settings, her interviews served as an assessment for psychiatric treatment. The screening block, the primary site for recruitment, was a patient's first point of contact with NIMHANS. There, a social worker would write down a patient's initial presenting symptoms, assign them a number, the patients would be interviewed by a psychiatrist who would then prescribe appropriate treatment (pharmacologic treatment was the most often type of treatment prescribed). The 'follow-up clinic' was the setting where patients came for psychiatric care (e.g., medication dose adjustments, symptom monitoring) after their initial visit to NIMHANS. D.R. recruited patients after their most troubling symptoms were identified. If participants appeared that they met inclusion criteria from report of their initial presenting symptoms, D.R. would explain study procedures, obtain informed consent, and then proceed with the interview. Per our study design, D.R. interviewed patients with prominent mood, anxiety, or somatic symptoms, but without psychotic, substance dependence, manic, or primary physical syndromes. All participants identified Kannada as their first language, and all interviews were conducted in Kannada.

D.R. trained in ethnographic interviewing with a psychiatric resident who had extensive expertise in working with the Explanatory Model Interview Catalogue. She had already been trained in SCID assessment for previous studies. Typically, patients would be interviewed with family members in the room, and occasionally, a family member would offer comments about the patient's symptoms. This followed established practices in the clinic. Once the interviews were completed, D.R. discussed the patient's diagnosis and symptoms with a senior psychiatrist

who would prescribe treatment. Treatments often consisted of antidepressant medications and follow-up visits to the clinic.

The study protocol was approved by the principal investigator's home institution's ethics board; informed consent documentation was obtained from all participants. We interviewed 60 men and women for a larger study, and we focused the present study on the reports of women. The quantitative analyses of the larger study were published elsewhere [2].

Data analysis

The interviews were transcribed into Kannada and translated to English by an experienced medical transcriptionist fluent in both Kannada and English. To characterize the sample, descriptive statistics were calculated on the socio-demographic information provided. In addition, the rate of depressive disorder amongst the women was determined from responses to the SCID. We then analyzed the qualitative data obtained from the Patterns of Distress and Stigma sections of the EMIC. We used Grounded Theory as a framework for analyzing the two sections of the EMIC. Grounded theory is a widely used technique for collecting and analyzing data about people's experiences [34]. As such, we did not begin study procedures with an a priori hypothesis about women and their experiences around depression. Instead, we built the theory through our analysis of the data that was collected in response to open-ended, ethnographic query.

The primary data analyst (DR), who had prior training in qualitative data analysis, began this analysis by reading through the English translations of the participants' transcripts and began making notes on the responses provided in the transcripts. She then read through the transcripts again to code the initial themes and collapse themes that appeared similar. Miles and Huberman [35] recommend this iterative process of memoing and coding. Finally, the themes were presented to the co-authors of this paper for evaluation of appropriateness. The final themes from this analysis were integrated with informal notes from the field work and presented in this report.

Results

In all, 32 women were interviewed. Seventy-five percent (75 %) of the women met criteria for current major depressive episode diagnosed with the SCID. The average age of the women was 36 years, and the average number of years in school for the women was 6 years. The vast majority (87 %) of the women were married, 9 % were widowed, and 3 % were unmarried. The average number of children the women had was 2. The median monthly family income for the women was Rs. 2,250. A conservative (and criticized) estimate of the poverty line in urban areas of India is defined as Rs. 960 per month per person in a urban areas (Rs. 780 in rural areas) [36]. If we set the family size to 4, the poverty line would be Rs. 3,840 for urban families and 3,120 for rural families. With these criteria, 75 % of the women in this study were living below the poverty line using urban figures.

The mental health backdrop

NIMHANS was first established as a hospital in the late 1800s. Over the years, NIMHANS has become known as the premier mental health facility in the region, and obtained national and international funding for its endeavors [37]. NIMHANS is one of four institutions in India to offer postgraduate psychiatric training [38]. Its research, educational, and service approaches span several disciplines, including neurology, psychiatry, social work, and clinical psychology. It is a governmentally funded institution, and as such, it primarily serves lower income communities throughout the region.

In terms of treatment, NIMHANS has the reputation of providing comprehensive and effective services. Primary care physicians, and often traditional healers such as temple priests, refer individuals to NIMHANS for specialized care. Although NIMHANS physicians are familiar with Ayurvedic and other traditional Indian medical treatments, treatment and training at NIMHANS is based primarily on Western allopathic medical models of care.

Like many other low and middle-income countries, India suffers from a critical shortage of mental health service facilities and providers [39]. In the outpatient screening clinic, six to eight psychiatric residents, about one-quarter of them women, would interview approximately one patient every 10 min from approximately 8 o'clock in the morning until about 3 o'clock in the afternoon. After these duties, the psychiatric residents would begin duties in the inpatient unit, and these activities would take their work well into the evening hours.

On the surface, NIMHANS is organized much like an academic research and training hospital in the United States: multiple buildings housed faculty offices and classrooms separated by discipline, one building contained the screening and outpatient treatment areas, and other buildings served as inpatient facilities. The grounds have dormitories for students set apart from treatment and training facilities. However, the organization of the space and ways in which patients were distributed within it, appeared to reflect a widespread public stigma associated with mental illnesses. The "back door entrance," which was most often used so that patients would not be seen

entering the facility, was located adjacent to a tuberculosis treatment center, a place that carried its own profound stigma. Inpatient units were organized by how much patients could pay for services rendered during their stay. Poorer patients, for example, lived in large rooms with 25–30 other people, whereas wealthier patients stayed in semi-private or private rooms.

A nursing shortage in India ensured that every bed had a cot next to it for an "attendant" (e.g., family member) who would care for the basic needs (e.g., bringing water, food, and medication) of the patient during his or her inpatient stay. Locked inpatient units existed for patients who were abandoned by friends and family and had no attendant during their stay in the hospital. In unlocked units, attendants were expected to keep track of patients' well-being, bring their medicines and food, and ensure that they did not leave the facility. This was unlike psychiatric inpatient unit organization in the United States, in which locked units existed for people who were at risk for harming themselves or others. NIMHANS staff members were proud of the facility's commitment to treating people with mental illness, leprosy, and HIV, regardless of the stigma these illnesses carried. Banners were often hung at entry gates, advertising NIMHANS's stigma-free approach to treatment. Although the people seeking treatment were subject to societal stigmas, NIMHANS service providers aspired to provide stigma-free care.

Women's lowered status and physical violence

During the interviews, physically and emotionally abused women told deeply affecting life stories. One of the first women interviewed, who we will call by the pseudonym Leela, was a 50-year-old woman with severe depressive symptoms. She appeared at the screening block alone, and told the screening staff that she was seeking treatment for pain. From a small village outside Bangalore, she had traveled by bus to be seen at NIMHANS. She wore a simple sari, traditional dress for women in south India. After she provided consent to be interviewed, her response to what brought her in for treatment was, "I don't feel happy. I haven't even seen happiness." She described that her husband was physically abusive and that her daughter committed suicide.

She explained some of her past: her parents arranged her marriage to a cousin when she was 15 years old. As is customary, she went to live with his family soon after they were married. From the start, she explained, her husband and his family would criticize her for not finishing school. The criticisms soon turned into beatings, from her husband and members of his family. The beatings continued over the years, and despite her growing symptoms of depression, she bore her husband three children, two sons and one daughter. Eight years before our interview, her daughter committed suicide after a confrontation with her father. She had wanted to spend time with friends, and as was his typical response, her father forbade her from spending time away from her family. In her hopelessness, Leela's daughter killed herself. Years later, Leela tearfully mourned her loss:

> "I might have been happy if my daughter was alive. Now, I feel tension, anxiety, and sadness. Always sadness. I don't sleep. I have many problems in my household… It is my husband that causes me to worry. What happens inside our house, no one can see."

D.R. asked her if there was somewhere she could go to escape her husband's beatings, and Leela stated, "We are poor people. There is no one to help me."

Other participants reported similar physical abuse, and cited their husbands' alcohol dependence as an associated factor. Gita (pseudonym), a married 37-year-old with three children, initially complained of headaches, but then explained, "I worry about my children's future. At least they should be on track no matter my husband's behavior. He has never been cool and happy; he is an illiterate fellow. [My parents] sent me to a poor family. It has become very difficult to survive for me. He uses drink always…creates scenes at home. I don't have support from anybody." In this way, Gita evoked an interaction between gender, poverty, and lack of agency that fueled her suffering, one that many of the women in this study echoed. She later described being raped by her husband, but said she felt she had nowhere to turn. Ultimately, she was not concerned about herself, but instead wanted to ensure her children's' well-being.

At the end of each interview, D.R. reported the patients' history and symptoms to a psychiatrist who would begin treatment. This, however, almost always took the form of prescription of an antidepressant medication. Leela and Gita were severely depressed and both were victims of reoccurring episodes of domestic violence, but there was nowhere they could go other than back to their families. In discussing the possibility of such women receiving help though a shelter, a senior female psychiatrist explained that in the clinic, these types of referrals are not given: women would never stay in such shelters, as it is not culturally acceptable for women to leave their marital homes. The stigma that would result from such an action would be intolerable. In the end, the women had come to NIMHANS seeking medications, not as a physical escape from husbands and family, but as an escape from the psychological consequences of domestic violence. The women interviewed in the follow-up clinic reported feeling aided by the medications, despite the fact that the medications did

nothing for the behaviors that they associated with their symptoms (i.e., the physical and emotional abuse), nor was it engaging the deeper social influences on the problematic behaviors (i.e., the disempowered social, cultural and economic status of women).

Social roles and structural violence

Another participant, we will call her Seetha, was 28 years old with severe depressive symptoms. Seetha had a primary school education, and like Leela, was from a small village in rural Karnataka state. Seetha had two children and worried about getting her daughter married. She presented for treatment with her (second) husband accompanying her. She was concerned about her daughter's welfare because she believed that she was too poor to save an adequate dowry. Her first husband, who was alcoholic, had recently passed away. She related that she remarried as a way of supporting her children. She now feels guilty that she did so, so much so that she described the guilt being the cause of an attempted suicide in the past. The mother of her first husband criticizes her for remarrying, and she is currently ill-treated by many of her neighbors,

> "Near my home there are some people who look at me and laugh. They make fun of me. I'm sad about this. I think about all this when its time… I feel like I'm doing things wrong. I just want to die. Yesterday I was sweeping the floor. I threw the dust somewhere, and (the neighbors) got mad and came to hit me. They give me a lot of trouble. My neighbor drank kerosene and died because her husband was treating her poorly. I wanted to do the same thing, but I worry about my daughter."

Seetha's experience demonstrates the extent to which many women's freedoms are restricted in India. Just as Seetha only received a primary school education, many female children are restricted from attending school, and they are set into the world unprepared for life independent of their husbands. As well, if they are later widowed and lose their primary source of income, cultural sanctions often prevent them from marrying again [40]. Seetha was ridiculed and criticized because she chose to marry again. Hers was an uncommon choice for women in India, even when widowed at a young age or to ensure the economic welfare of children, and in Seetha's case, the stigmas of remarriage have undermined her well-being and appear to have laid the grounds for severe depression.

Another woman interviewed, given the pseudonym Rupa, lived in urban Bangalore and came from a more middle class background. She was 28 years old and worked as a medical transcriptionist. Despite her differing circumstances from the other women whose stories are given here, Rupa also understood the need to conform to a social role and acutely felt pressures of structural violence. Rupa cried as she told the story of how she and her husband married for love and in the end, both sets of parents separated them. She had a small child. She is now raising that child alone, and she explained, "I feel like I should kill myself or go far away from everyone … sometimes I get overcome that no one will take care of my daughter's life".

Many of these women said that their concerns were rooted in worries about their children's future. The women who had daughters were particularly concerned about settling their daughters' marriages. These concerns kept them awake at night, and they experienced headaches, stomach pain, feelings of hopelessness and helplessness. These women's depressive symptoms appeared to be related to their desperate financial situations, lack of choices to remedy these situations, and sometimes the emotional and physical violence they experienced. At the same time, the children have been a motivating factor in these women's desires to be well, stay alive, and perhaps even seek ways to remedy their situation.

Discussion

In the present study, the women's depressive symptoms appeared to be associated with structural violence and as Sen described, 'capability deprivation.' One woman, Seetha, was verbally and physically assaulted by her relatives and neighbors because she was a widow who remarried. Cultural norms restricted widows' ability to advocate for themselves, and Seetha was desperately concerned about her children's financial stability, particularly around securing an adequate dowry for her daughter. Seetha's apprehension around satisfying socio-cultural expectations for herself and her daughter exposed her limited agency as a widow, and was associated with her reports of sadness, anxiety, and suicidal ideation. Similarly, Leela and Gita suffered from domestic violence with little ability to escape from their circumstances. Leela's daughter's freedoms were restricted and her daughter committed suicide. Leela and Gita experienced profound sadness as a consequence of their interpersonal familial experiences and both presented to the NIMHANS screening block for psychiatric treatment. Lastly, Rupa's family's opinions of her marriage and going against local customs led to her and her husband's separation and her own depressive symptoms. Rupa clearly demonstrated how her love for child motivated her to stay alive in order to look after her daughter's welfare.

Each of the women whose stories we have examined in this study, and a majority of those whose narratives we have not shared, sought medical treatment for psychological symptoms that appeared to be, at the least, aggravated

by their unequal, marginalized status as women in Indian society. Seen one way, these women presented for treatment at NIMHANS seeking biomedical treatment of their suffering, but their reports associated their symptoms with poor interpersonal experiences and socio-culturally defined power differentials that stacked the odds against their well-being. This phenomenon is far from unique. Scheper-Hughes [41] discussed a similar situation among the people of Bom Jesus da Mata in Brazil. She described a process in which hunger has become medicalized into a psychological syndrome and treated with medications. She stated,

> "Those who suffer chronic deprivations are, not surprisingly, nervous and insecure… Gradually, the hungry people of Bom Jesus da Mata have come to believe that they desperately need what is readily given to them, and they have forgotten that what they need most is what is cleverly denied (pp. 169–170)."

Scheper-Hughes's informants desperately needed food, but somehow it was easier to get them medications to treat the psychological consequences of hunger than food itself. Among women in India, a parallel can be drawn. Though they suffer from depressive symptoms, what many of the women in our study might have benefited tremendously from economic agency and access to educational opportunities. The medications may help these women to cope or mitigate their suffering by relieving symptoms in the short term, but antidepressant medications will not solely resolve a widespread vulnerability of women in India to experiences of illness and suffering.

This notion is also consistent with the perspectives of Foucault and others who, in a growing area of investigation, point to the 'medicalization' of social phenomenon [42, 43]. Good [44] explained that we often expect that medicine is the universal remedy that will help us restore order to our lives and relieve our suffering. In the end, medicine disappoints, as "medical practice can never fully contain the moral and the soteriological (p. 85) [44]." Perhaps other options, such as working for increased acceptance of domestic violence shelters as refuge, enforcement of laws against gender-based violence, as well as education and empowerment campaigns for women, might prove to be helpful solutions to improving gender-based suffering in India. These alternatives would also lessen the burden on Indian psychiatric clinics, a segment of the Indian health care system that is already quite overtaxed.

Most of the women whose stories are recounted here came from poor, rural areas in Karnataka state, and often the women traveled far, from small rural villages to the sprawling urban jungle of Bangalore, for treatment. The women sought escape from the social inequalities they experienced, poverty and low status as women appeared to have led to their worries and left them without options. Farmer related that "it is poor women who are least well defended against these assaults (p. 44) [45]". Years before, Kleinman made similar observations, "Our Chinese patient samples are predominantly individuals from stigmatized class background, in vulnerable positions, who are powerless to alter work, family school, or political situations (p. 175) [46]". He also observed the "relative powerlessness that women find themselves in cross culturally (p. 233)." Women from more privileged backgrounds may experience the consequences of gender inequalities, but have ready access to resources that can help with coping. However, poor women in India have difficulty leaving their circumstances. Although stigmatizing in itself, the easiest pathway to help them cope with their situations may have been to take on the label of having mental illness and begin psychiatric treatment.

Linkages such as these, between illness and societal structures, are not new. Kleinman long ago discussed, "the social sources of human distress are local human contexts of power that distribute resources unequally…risk for illness onset and psychological distress is in large measure the result of one's place, and particularly one's relationships, in local cultural systems (p. 168)." More recently, an Indian team of investigators found that social and situational factors, such as financial problems and victimization, contributed to deliberate self-harm behaviors among men and women seeking treatment at an urban general hospital in Mumbai [7]. Findings from the present study add to the growing body of literature that associates poverty, female gender, and depression.

Seen more optimistically, the women in this study have pulled themselves up from their depression, and instead of isolating themselves or worse, they have sought treatment for their symptoms. These women braved the stigmas associated with seeking treatment at NIMHANS, which is even more remarkable in light of the fact that recent studies have found that negative beliefs about antidepressants often lead people in India to discontinue taking them [47]. Furthermore, several researchers have noted that suicide rates are high among women from India, and likely underestimated [16]. The women in this study instead have braved the stigma associated with psychiatric treatment seeking and requested a remedy for their pain. The women indicated that their motivation in doing so was often focused on their children, and that their caring children were their main reason for seeking treatment. Ultimately, concerns around children have empowered these women such that they continue to see life as worth living.

There were several limitations to this study. First, structural and physical violence against women is a widespread problem globally, and our interviews were

performed with a narrow population of 32 poor women seeking psychiatric treatment in Karnataka state, South India. Thus, these results may have limited generalizability, even in the South Indian context. These data were also collected cross-sectionally, and thus causal interpretations from this data should be interpreted with considerable caution. Our discussion of associations between poverty, female gender, and depression should be understood in light of the fact that various other factors not studied here (e.g., genetics, physical environment, and social capital) may also influence depression. Our results here should be considered as part of a body of work that relates women's mental health to socio-economic status within a broader socio-cultural context. Regardless of these limitations, we believe this examination of the lives of distressed women seeking psychiatric care in a mental health center in South India raises important questions about the kinds of programs and initiatives that might help to decrease the suffering of women in India.

Conclusion

More long lasting solutions to gender inequalities in India might come about by approaching the problem at *multiple levels*, encouraging women's agency and capability while also providing them with immediate means to cope (e.g., pharmacologic, psychotherapeutic) with their social environment. In other words, if we focused on empowering women and building upon their strengths (e.g., connection to children), as well as provide immediate tools to help cope with their situations, there is a possibility that we may see fewer cases of depression develop over the long term. Women's status might also be uplifted straightforwardly by helping poor women access resources such as education, nutrition, and employment. Furthermore, women should enjoy freedom from violence, and perpetrators of violence against women should not go unpunished. Physicians, social scientists, and other advocates can work together to make a valuable contribution to ensuring that basic human rights are respected for women, worldwide.

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