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Research Paper

An Objective Look at the Presence and Severity of Mental Health Issues in Indian Men in Gujarat

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ABSTRACT

The aim of this paper is to present an objective look at the presence and severity of mental health issue in men across the selected intervention districts in Gujarat and in the COVID-19 era. The survey was undertaken between June 2021 and December 2022. It was largely representative of the population, as 168,639 people were taken from 50,780 households of 7 districts of Gujarat. The survey population aged 15 to 65 years. 70,767 men were screened for anxiety, depression, suicidal thoughts (if scores severe on screening). Conditions which they were facing were explored by a semi structured script accompanied with PHQ4 as a screening tool. They were further provided with psychological intervention(s) in the cases where mental health challenges were reported. This paper presents selected findings for the pattern with respect to socio-demographic differences in the male population who reported mental health problems N=2141. Our data showed us that males exhibited a prevalence rate of 3.02% and we thus decided to take a look into the socio-economic and demographic data we had available. It was found that, unemployed males exhibited more mental health issues than males in other age groups. Illiterate males were more likely to experience severe MH issues. Males who were divorced/separated/widowers were more likely to experience severe and moderate MH issues as a whole than other marital groups.

Keywords: *PHQ-4, Anxiety, Depression, Mental Health Screening, COVID, gender differences, help seeking behaviour*

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Male suicide is a major issue that needs to be addressed. Suicide in men is a hidden epidemic due to lack of public knowledge and understanding of few preventive measures. Male suicide rates in India are 1.4 times higher than the global average (Dandona, 2018). Male suicide rates rise consistently with age, peaking in the late 40s, then dropping dramatically and climbing again in the 80s. There appears to be a shift in this suicide trend, male suicide lags behind changes in the age-specific prevalence of this cause of death (Pirkis, 2017).

To address male suicide, it is necessary to first understand how suicidality develops in males and how it can be diagnosed early on. A longitudinal study of 13,884 men discovered that one facet of western masculine norms might lead to men's suicide ideation. Men have 34% higher odds of having suicidal thoughts than women, but suicidal ideation is not a reliable predictor of an impending attempt (Pirkis, 2017). A qualitative study found that suicidal thoughts can be decreased through practical aid to manage crises and assisting men to focus on commitments. 67% of males who had previously attempted suicide said that thinking about the repercussions for family helped avoid future attempts. However, there is still controversy about the impact of biology and social influences on suicide (Shand, 2015).

Depression in men:

According to epidemiological studies, men have lower prevalence of unipolar depression in comparison to women.Three major explanations have been advanced for why men are less likely to suffer from depression than women. First, due to aspects of male socialisation, men are hesitant to acknowledge depressive symptoms. Second, externalising symptoms (e.g., anger, alcohol abuse, risk-taking) are not diagnosed as such. Third, men experience depression differently than women, with different symptoms, so the standard operational criteria for depression do not apply to them. A recent systematic review compared symptom patterns in men and women with unipolar depression and discovered only minor differences.

However, if men's depression differs qualitatively, many will not be 'diagnosed' as depressed and will thus be absent from the literature. There is some evidence that men describe depression using language (e.g.,' stressed,' 'angry,' 'tired') that does not match existing clinical criteria or that men endorse different warning signs of depression (e.g., being 'irritable,' 'on auto-pilot,' and more aggressive towards others) (Rutz,1995) (Rice, 2015).

Finally, the concept of male depression raises the issue of depression's ontological status, as we must seek a theoretical definition of depression that encompasses various presentations.

Substance Abuse, Dependence and Use in Men

Alcohol has a major impact on men's mental health, men being twice as likely as women to develop a major alcohol consumption issue. It is also a risk factor for a variety of serious disorders and causes of death, with the incidence of global mortality attributed to alcohol use being six times higher for males than for women. In terms of reducing alcohol-related risk in men, a systematic review of long-term outcomes in alcohol dependence discovered that men have significantly worse outcomes than women. According to CDC in 2020 men are more likely to binge drink than women. Men also have higher risk of alcohol abuse disorder than women.

Despite widespread public concern, the predominance of men in opioid overdose deaths has only recently come to light, and little is known about the causes of this significant gap in

overdose mortality. We hypothesise that the same social pressures and coping methods that induce males to overuse alcohol also nurture other forms of substance abuse (Back, 2010).

Understanding coping strategies used by men:

Recent studies have linked the use of negative coping styles to some men's rigid adherence to stereotyped features of masculinity, such as the use of alcohol and drugs to numb distress, the hiding and ignoring of negative emotions, engaging in risky behaviours, or valuing self-reliance and autonomy over professional care (Whittle, 2015)

These measures can raise the risk of suicide, and some men report attempts to redefine manly coping. A group of researchers in Australia investigated positive coping techniques utilised by men, and found that some men were more comfortable with 'typically masculine' ways while others were open to employing less 'masculine' strategies. Men use mental health care at a significantly lower rate than women (Proudfoot, 2015).

Research data suggests that men are reluctant to access mental health care due to a need for control, self-reliance, or a tendency to dismiss symptoms (Doherty, 2010). Conforming to gender norms for men has a detrimental impact on help-seeking, causing the therapy to be postponed until internal resources are depleted or a crisis point is reached. Research suggests that men do not understand the need for care, that immediate support networks do not notice male-specific warning indicators, that diagnostic criteria do not discover men with mental health problems, and that men delay treatment until problems become too severe to ignore (Wong, 2017).

The idea that men have gender-specific risk factors for prenatal distress that are absent or operate to a reduced level in women was a primary incentive for the current investigation. Men may have fewer support networks than women, relying mostly on their relationships for assistance. They may lack strong fathering role models since they were raised in a time when males were less involved in birth and child-rearing (Shah, 2007). Males are known to be less likely than women to seek help for emotional difficulties and instead may turn to maladaptive techniques such as alcoholism or risk-taking behaviour. Up to 15% of new fathers may have a partner who suffers from prenatal or postnatal depression, and these men have a 2.5 relative risk of elevated mood screening scores at six weeks postnatal. (Hunt, 2017)

Postnatal anxiety manifests differently in men and women, and non-melancholic severe depression is twice as common in women as in males throughout the childbearing years. The cause of this disparity is less understood, but some experts feel there is a real difference, citing biological, psychological, and social aspects. (Player, 2015).

Masculinities and it's effects on men's coping and mental well-being:

MCritical perspectives regarding men's health have arisen from feminist critiques that highlight the socially constructed aspect of gender while questioning hegemonic masculinity and gendered power relations. In recent decades, two fundamental theories for understanding gender have evolved to highlight this complexity. Firstly, gender as performance and secondly, the building of various masculinities. In the 1980s, Australian research revealed a notion of numerous and hierarchically arranged 'masculinities' (Connell 1995). Gender was considered dynamic and enacted by men in different realms of social life, and diverse masculinities contended for power and normative status. Hegemonic masculinities were socially perceived as the natural condition of masculinity, and men

practising masculinities that were incompatible with dominant constructs of hetero-normative masculinity risked being singled out for scorn and marginalisation. This proliferation of masculinities had other repercussions, such as social dangers for men attempting to replicate hegemonic ideals and increased levels of substance misuse. Additionally, research has shed light on how social factors associated with the marginalisation of male homosexuality contribute to distress and psychopathology.

Performativity and hegemonic masculinities emphasise the production of masculinity in everyday social life. This understanding of gender as diverse and produced in practise contrasts with the binary notion of men/women deconstructed by feminists over the past decades.

Men and their wellbeing

Wellness is a concept that is increasingly being employed across a variety of fields, and it has consequences for how we think about men's subjectivities. It is used in a variety of contradictory ways to conceptualise subjectivity and sociality, and lacks conceptual clarity (Hanlon and Carlisle 2008).

There is a divide in psychology between writers who conceive well-being as primarily about happiness and others who see the term as encompassing more complicated constructs such as personal growth, acceptance, authenticity, and life purpose. The sociology of wellbeing investigates the relationship between the individual and the collective, and individualism, emotion management, and a feeling of personal responsibility and action are among the various lay understandings of wellness (de Chavez et al. 2005).

Recent research into cancer support groups has revealed gender differences in knowledge and assistance. Gooden and Winefield (2007) discovered that when women explicitly communicated their emotions, men tended to suggest emotion. Brownhill and colleagues (2005) discovered that while men and women (who identified as being 'down in the dumps') could process their distress in similar ways, men, in particular, reported managing their distress differently, such as avoiding distress. Danielsson and Johansson (2005) found that women had a greater vocabulary for expressing feelings than males in a Swedish study that compared a small number of narratives of men and women with a diagnosis of depression. Men, on the other hand, talked more about keeping emotional distress discussions to themselves while being more inclined to vent their aggressiveness. Women were also more internally focused, with feelings of self-blame and remorse, whereas men talked about external causes that had unexpectedly struck them down (Danielsson et al. 2009). These findings suggest that men may present with distress/depression later than women.

Help-seeking in times of distress

The conventional narrative in the literature regarding masculinity is that males are more reluctant to seek treatment than women, regardless of their health concerns. However, recent studies suggest that the relationships between gender and help-seeking are more nuanced than previously imagined. Biddle and colleagues (2007) found that young participants of both genders engaged in the process of 'lay diagnosis' in an attempt to make sense of their discomfort. MacLean et al. (2009) found that both boys and girls felt under some pressure to conceal health symptoms, particularly to peers. Hunt and colleagues (2009) observed that while there are no research comparing consultation rates for men and women with the same illnesses, both men and women may understand help-seeking for health as a last resort.

The COVID-19 pandemic has had a profound impact on men's mental health, causing significant distress and a range of related issues. Studies have shown that men may be particularly vulnerable to mental health problems during the pandemic, as they face unique challenges such as job loss, financial strain, and increased domestic responsibilities. Additionally, men may be more likely to experience feelings of isolation and loneliness, which can exacerbate existing mental health conditions or lead to the development of new ones. Furthermore, traditional masculine norms that prioritize stoicism and self-reliance may discourage men from seeking help for their mental health concerns.

However, some study in the United Kingdom reveals that, as compared to women, men have a greater threshold for suffering before seeking help, and women are more likely than men to seek aid from family and friends. Men may be reluctant to seek assistance due to hegemonic standards, fear of showing their emotional vulnerabilities, and mistrust of health professionals and institutions. Women are more competent than males in conveying their discomfort to specialists, leading to a higher risk of acquiring a mental health diagnosis. (Mirowsky and Ross 1995). Because some men are unable to express their discomfort, their emotional difficulties may remain hidden from specialists (Brownhill et al. 2005 in addition to it, professionals may overlook emotional suffering in males. (Courtenay 2000, Moller-Leimkuhler 2002).

It can be argued that psychiatric classification systems such as the Diagnostic and Statistical Manual bias professionals in favouring female presentations over male presentations, and that institutionalised healthcare can obscure male subjectivity. Additionally, there is a growing realisation that people might build their own skills to self-manage their health, sometimes marginalising professional engagement. Finally, health-promoting behaviours must engage with various viewpoints on health, dangers, and life, and the importance of health is defined by a complex interaction of meaning, self, embodiment, and context. Therefore, viable explanations regarding how men cope with and seek help for their distress must address the working of various meaning frames.

Objective

The objective of this paper is to provide a detailed and impartial analysis of the presence and severity of mental health issues among men in selected intervention districts of Gujarat, both before and during the COVID-19 era. The survey, which was conducted between June 2021 and December 2022, was conducted on a large, representative sample of 168,639 individuals from 50,780 households across 7 districts of Gujarat, covering the age group of 15 to 65 years. The paper aims to present selected findings on the socio-demographic differences in the male population that reported mental health problems (N=2141). Using PHQ4 as a screening tool, anxiety, depression, and suicidal thoughts were screened in 70,767 men, and further psychological interventions were provided where necessary. The analysis revealed that males exhibited a prevalence rate of 3.02% for mental health problems, and the paper focuses on exploring the socio-economic and demographic patterns associated with this finding. The paper sheds light on various factors, such as unemployment, illiteracy, and marital status, which were found to have a significant impact on the mental health of men in the selected districts of Gujarat.

METHODOLOGY

The survey was undertaken between June 2021 and December 2022. It was largely representative of the population as 168,639 people were reached from households of 7 districts of Gujarat. The survey population aged 15 to 65 years. 70,767 men were screened

for anxiety, depression, suicidal thoughts (if scores severe on screening). Conditions which they were facing were explored by a semi structured script accompanied with PHQ-4 as a screening tool. 70,767 males were screened using the PHQ-4 out of which 2141 scored >=3 on PHQ-4 (reported mild, moderate or severe mental health issues) and 68,626 scored <3 on PHQ-4.

Severity of mental health issues were defined by scores on PHQ4:

- ➢ PHQ-4 Scoring: Total score ranges from 0 to 12,
- ➢ None: 0-2
- ➢ Mild: 3-5
- ➢ Moderate: 6-8
- ➢ Severe: 9-12

They were further provided with psychological intervention(s) in the cases where mental health challenges were reported. This paper presents selected findings for the pattern with respect to socio-demographic differences in the male population who were screened for mental health issues.

Sample size: N=70,767

Inclusion criteria

Respondents within the age range of 15-65 at the time of interview were included.
Males who agreed to be screened on PHQ 4 were included in this data set.

Exclusion criteria:

Respondents below 15 years were excluded.

Socio-demographic profile

The socio-demographic data of marital status, occupation and were collected as a standard. The socio-economic status could not be successfully elicited, in many respondents, hence cannot be used as a reliable marker in socio-demographic profile for the scope of this paper.

Analysis

Descriptive analyses were calculated by the use of SPSS Version 29.0.0.0(241). To examine data separate cross tabulations were conducted to determine Chi-square, setting statistical significance at $p < .001$.

RESULTS AND DISCUSSION

Marital Status with MH category Cross Tabulation

		Normal	Mild	Moderate	Severe	Total
Married	Count	53553	1609	113	20	55295
	%	96.80%	2.90%	0.20%	0.00%	100.00%
Unmarried	Count	13513	253	44	19	13829
	%	97.70%	1.80%	0.30%	0.10%	100.00%
Divorced/Widower/ Separated	Count	1560	73	6	4	1643
	%	94.90%	4.40%	0.40%	0.20%	100.00%
Total	Count	68626	1935	163	43	70767
	%	97.00%	2.70%	0.20%	0.10%	100.00%

Chi-Square Tests

	Value	df	p-value
Pearson Chi-Square	102.192	6	0

The above data set brings up a few interesting observations. When it comes to severity of MH issues, unmarried people (0.10%) and divorced/widowed/separated persons (0.20%) report a higher prevalence rate of severe MH than married people who reported 0.03% severe MH cases.

A similar trend is observed in moderate MH cases unmarried people (0.30%) and divorced/widowed/separated persons (0.40%) report a higher prevalence rate of moderate MH than married people who reported 0.20% moderate MH cases.

However, this trend changes for mild MH cases where divorced/widowed/separated persons showed a prevalence rate of 4.40% as compared to married persons (2.90%) and unmarried persons (1.8%%)

Educational Status with MH category Cross Tabulation

		Normal	Mild	Moderate	Severe	Total
Illiterate	Count	1742	93	9	6	1850
	%	94.20%	5.00%	0.50%	0.30%	100.00%
School Education	Count	48096	1419	130	32	49677
	%	96.80%	2.90%	0.30%	0.10%	100.00%
Graduate and above	Count	18788	423	24	5	19240
	%	97.70%	2.20%	0.10%	0.00%	100.00%
Total	Count	68626	1935	163	43	70767
	%	97.00%	2.70%	0.20%	0.10%	100.00%

Chi-Square Tests

	Value	df	p-value
Pearson Chi-Square	102.808	6	0

When we took a look at the above table we came across a pattern. When it comes to severity of MH issues in educational groups; illiterate people exhibited the highest prevalence of mild, moderate and severe MH issues at 5.0%, 0.50% and 0.30% respectively. People with a school education showed corresponding prevalence rates of 2.90% mild MH issues, 0.30% moderate MH issues and 0.10% severe MH issues respectively. The least prevalence rates were observed in people with a graduate and above education level with 2.20% mild MH issues, 0.10 moderate MH issues and 0.02% sever MH issues.

Occupational Status with MH category Cross Tabulation

		Normal	Mild	Moderate	Severe	Total
Unemployed	Count	8114	376	72	26	8588
	%	94.50%	4.40%	0.80%	0.30%	100.00%
Student	Count	7867	82	6	2	7957
	%	98.90%	1.00%	0.10%	0.00%	100.00%
Employed	Count	52315	1469	85	15	53884

	%	97.10%	2.70%	0.20%	0.00%	100.00%
home-maker	Count	330	8	0	0	338
	%	97.60%	2.40%	0.00%	0.00%	100.00%
Total	Count	68626	1935	163	43	70767
	%	97.00%	2.70%	0.20%	0.10%	100.00%

Chi-Square Tests

	Value	df	p-value
Pearson Chi-Square	431.559	9	0

When we took a look at the above table we came across a pattern. When it comes to severity of MH issues in occupational groups; men who were unemployed exhibited the highest prevalence rate of Mild MH issues with 4.40% followed by employed males (2.70%), males who identified as home-makers (2.40%) and students (1.00%). Similar patterns were observed when it came to moderate and severe MH issues, where unemployed men had higher prevalence rate of 0.80 % -moderate MH issues and 0.30% severe MH issues respectively as compared to home-makers (moderate MH issues-0.00% and severe MH issues - 0.00%); employed people, (moderate MH issues-0.20% and severe MH issues - 0.02%) and students (moderate MH issues-0.10% and severe MH issues - 0.02%).

Mental health services should be included into NCD preventive and control programmes, as well as children's health, adolescent health, geriatric health, and other nationwide disease management programmes. Specific programme implementation methods and guidelines for exercises, activities, human resources, finance, and evaluation should be offered to all state governments. Screening for common mental illnesses (depression, suicidal behaviour, drug use issues, etc.), wellness (through yoga and other means), and continuity of treatment / referral facilities should be an inherent component of all of these programmes. Furthermore, contemporary academic establishments and employment networks should be reinforced to integrate a mental health focus. Based on the findings of preliminary studies, such programmes should be launched in DMHP sites initially.

Mental health issues have been a significant concern in India, particularly in rural areas, where access to mental health services is limited. AB-HWC aims to bridge this gap by providing mental health services as part of its primary healthcare services.

Under AB-HWC, trained healthcare providers, including medical officers, nurses, and community health workers, are deployed to provide mental health services to patients. These services include screening, diagnosis, and treatment of common mental health disorders, such as anxiety and depression. The healthcare providers are also trained to provide counseling services, including psychoeducation, stress management, and behavioral therapy.

Moreover, AB-HWCs are equipped with telemedicine facilities, enabling patients to consult with mental health specialists remotely. This feature has been particularly useful during the COVID-19 pandemic, where physical distancing has made it challenging for patients to access mental health services.

Limitations and strengths of the study

The study did not examine schizophrenia, personality disorders, bipolar affective disorder, and other mental health issues. The homeless, inmates, and elderly were not included in the

study. It may have had a small impact on the population but was underrepresented elsewhere, especially where qualified interviewers are needed. Due to time and energy, answers and participation are down globally. Notwithstanding its shortcomings, the study has several merits, including the vast data pool that accurately represents the population.

Demographic data suggests a much-needed study of mental health issues in different age groups for men.

CONCLUSION

We come to see that men seem to deal with a lot of issues without recourse and resolution as they don't really reach out to seek help.

Directions for research and policy

Societal structure means that men to keep silent about their distress and experiences, which exacerbates men's difficulty in finding the means to express, acknowledge, manage, and seek help for their challenges. This condition also implies that male anguish may continue to be played out in the face of institutional silence, contributing to the narrative that men do not require more care in this area. Nonetheless, results such as significant anxiety and depression males makes it imperative that future study on men in distress could benefit from focusing on a variety of topics. For example, fleshing out new understandings (and perhaps new forms) of subjectivity and men; better elucidating the intersection between performativity and subjectivities; further clarifying discourses and narratives of distress and wellbeing between men and women; beginning to explore how men engage with 'wellbeing' (and challenging the 'men as deficient' narrative); research that considers the influence of bounded social circumstances as well as wider social contexts.

Going beyond the current research focus on mental diseases (such as depression) and women to investigate the rich formation of subjectivities and distress appears worthwhile. Enabling males to identify their own discomfort in qualitative research will most likely yield crucial insights into 'invisible' aspects of their emotional lives. Presently, we know little about the languages and stories males employ before their problems potentially grow to become a 'disorder'. Yet, qualitative approaches, such as in-depth interviews, are likely to bring difficulties. Even when comparing samples of men and women, it is difficult to distinguish which differences are due to societal gender relations, masculinity performance and construction, or other dimensions that may influence subjectivities, such as circumstance, social class, or simply being a human being in the twenty-first century. There is consequently a case to be made for greater comparative research between men and women, as well as a focus on men's subjectivities in particular.

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