HEALTH DISPARITIES AND STRESS MANAGEMENT AMONG MARRIED COUPLES: AN ANTHROPOLOGICAL PERSPECTIVE

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Abstract

The title of the article is "Health Disparities and Stress Management among Married Couples: An Anthropological Perspective". This research work aimed to study the relationship between the stress index and socio-economic constraints of the married couples, who suffered from non-communicable diseases. The qualitative research design was used to gather and investigate the facts. The data was composed through using in-depth interviews and observation method in Hearts International Hospital, Rawalpindi and it was analyzed through content analysis in order to inference the data from interviews. It was concluded that there was a significant relationship between the stress index and socio-economic conditions among married couples who have been suffering from non-communicable diseases. In order to maintain the social status and meet both ends the couple had to work hard and subsequently they began to face health deteriorations along with the development issue of their children. Therefore, the health centers should take reforms in order to aid low-income couples regarding the betterment of their health and development issues of their children.

Keywords: Health, Income inequality, management, Socio-economic status, stress

Introduction

Medical anthropology is the fastest developing subfield of anthropology and epidemiology. It explores disease distribution and determinants. The association between medical anthropology and epidemiology is eccentric, as both disciplines discuss the origins and ramifications of illness in biological, social and cultural terms. The levels of methodological and theoretical focus is being expended in multi-site, cross-disciplinary studies in the fields of cultural studies of science and technology, research on health systems, epidemiology of health care, clinical medical anthropology, infectious disease ecology and preventive analysis. The opportunities for interaction between anthropologists and epidemiologists have been given by both of these cross-disciplinary fields.

The US health initiative defines wellbeing differences as a health difference that is intimately correlated to cultural, financial, and/or ecosystem disadvantage, and states that structural barriers disproportionately affect groups of people who have systematically faced greater obstacles to health because of their racial or ethnic group; religion; socioeconomic status; gender; age; mental health;

cognitive, or physical disability; gender uniqueness; terrestrial location; or other factors. Therefore, disparities in health go beyond mere variations in group or specific population health status. Discrepancies in well-being arise from systemic inequities that are unequal, unfair and preventable. Health gaps are growing as a result of social inequality impacting generations of societies, resulting in increased risk and reduced wealth throughout the course of life based on group social stratification (Gordis, 2009).

Limited health awareness has been linked to poor cardiovascular health outcomes including increased risk of heart disease, death, morbidity, and hospital readmissions, as well as reduced quality of life. Limited health literacy in the young, the elderly, the less educated, minorities, immigrants/refugees and the chronically ill/disabled are more prevalent. Limited health literacy may be a mechanism through which health inequalities are perpetuated in these populations (ibid).

Self-care is a key aspect of the prevention and treatment of any disease. In many ways, limited health awareness can have an effect on self-care. Knowledge of one's health risk is needed to fully understand the lifestyle changes needed, identify worsening symptoms, and decide when to contact the health care provider for assistance. Limited health awareness is associated with less information and may have an effect on individual's self-care and cardiovascular health outcomes. The ability to engage completely in self-care requires the ability to solve problems and to think. Such activities may be challenging for individuals with limited health literacy. Health care providers should determine the patient education level, of all their patients and determine if there may be issues with the ability to care for oneself (ibid).

Cardiovascular disease often leaves patients with high levels of emotional distress (Moser et al., 2010). The emotional response encountered, however, is much greater than expected, with the incidence of main despair in those having an acute myocardial infarction (MI) nearly three times that of the healthy population (Thombs , et al., 2006). The Diagnostic and Statistical Manual of Mental Disorders-IV estimates that prevalence towards major depression to be 2-9% in the general population while rates for survivors of acute MI's are thought to be 19.8% (APA, 2000); (Thombs , et al., 2006). Besides this increased rate of depression following a heart event, the important point to note is that depression is also related to coronary heart disease (CHD) development. Depression, in particular, is a strong risk factor for CHD development with a relative risk (Lett, et al., 2004); (Rugulies, 2002).

For those diagnosed with a major depressive disorder, this risk is even greater than for those with milder depressive symptoms (Carney, R M; Freedland, K E, 2003). Besides being a risk factor for CHD progression, depression is associated with much poorer prognoses for patients who have already been diagnosed with CHD (Carney, R M; Freedland, K E, 2003). In fact, CHD patients diagnosed with comorbid clinical depression have a two-fold higher mortality rate in the two years after diagnosis relative to those without depression (Barth, Schumacher, & Herrman-Lingen, 2004). Likewise, in the 12 months following the initial MI, distressed patients who have recently had an MI have a double rise in mortality risk (van Melle, et al., 2004). So, despair remains a strong mortality risk factor up to five years after the initial MI (Carney, et al., 2008).

Socioeconomic status (SES) measures are disappointingly confined, but the particular observations in both analyzes are relatively consistent: people with limited socioeconomic status, especially when considering educational attainment, not only had the greatest incidence of most lifestyle factors for CVD and were also less able to pinpoint the health conditions. The correlation between SES and risk factor frequency was especially strong for nicotine and extra weight, but less apparent due to lack of activity and higher blood glucose levels and cholesterol (Squires , Bruce P.;, 2000).

Study Statement

To study the relationship between the stress index and socio-economic constraints of the married couples, who suffered from non-communicable diseases.

Review of Literature

According to Dunn (1979), both epidemiology and medical anthropology are academic areas that study illness and behavioral differences. Both of them have values in their soul. History and tradition distinguish the sciences, epidemiology appears to be both descriptive and quantitative, and medical anthropology to be literary and qualitative. Epidemiologists use past data or data collected from the present to the future to explain trends in illness. They use prospective research formats to monitor a group of people over time, track their susceptibility to possible disease causes, and determine how disease rates differ depending on whether an individual has been exposed or not. Particularly worthy of attention is the idea of a behavioral epidemiology that focuses on the health-related effects of action and perception.

Dressler (2011) suggests that a meta-theoretical framework for the study of stress and illness is prominent in an anthropological approach. An ethnographer must first grasp what episodes and situations, as well as social connections, signify within a culture in order to comprehend what a stressor or resistance mechanism is. What, even so, is the symbolic significance of various connections and circumstances? Is an incident or circumstance occurring, or having a specific sort of interaction, a source of considerable worry for men, or only a matter of indifference? The purpose of investigating these common perceptions is to assess the influence of culturally relevant stressors or exposure to culturally relevant resistance services on health outcomes.

In Modern culture, women were considered the much more emotional race, making them perfectly suited for homemaking and supporting careers, whereas men were seen as the intelligent ones, worthy of achievement in the logical sector and science fields. To anthropologists getting legal recognition in sciences, any formal study of unattractive, irrational emotional experiences was inevitably trumped by a masculine significance-centered and analytical work paradigm. Maybe there is yet another methodological explanation why anthropologists do not recognize feeling as a conventional subject (Lindhlom, 2007).

Medicinal anthropology is the study of well-being, illness, sickness, and cure through people living in one community. This gives an illustration of peoples practice and how community followers channel their actions, express thoughts, and coordinate resources. This involves how human communities recognize their life and react to the challenges. This comprises admittance to, or exclusion from, well-being reinstating and well-being maintenance services by communities by the power and economic systems of societies. In addition, it makes the overall study of social backgrounds, it examines the significance of signs of illness and suffering.

Throughout medical anthropology, the term treatment refers not only to official treatment, but also to any and all treatments designed to address what lay people and professionals consider to be the condition that needs care. In this sense, medicine involves treating diseases such as tuberculosis, and malaria. It also involves efforts to reduce public interference, as well as the song of a shaman about his magical quest to bring back a dying person's soul or the study of mystical therapists in Mexico (Finkler & Kaja, 1985).

Dressler (2011) supports his claims that for over half a century, the impact of cultural factors on the result of illness has been a fruitful area of research in medical anthropology. The primary focus of this research was on the worldwide dislocating consequences of colonialism and post-

colonialism on local people, namely market penetration, political influence, and information from distant power centers. The substantial link between exposure variation and health outcomes in response to these modernization factors sparked a new set of ideas regarding how unfavorable events and conditions influenced these effects.

Dressler (2011) further states that stress and illness studies in medical anthropology have begun to concentrate more recently on basic social and cultural mechanisms and their consequences for human biology. This is due to the fact that human biology is inseparable from society at many stages. We are the way we are, because of the biological and cultural evolution of the centuries have been a constant, interconnected and are biocultural process.

According to Townsend (2011), human scientists and bioarcheologists have not been alone in trying to understand hunter-gatherers and a tropical forest farmer's health condition. Cultural ecologists, geographers and ecological anthropologists carried out ethnographic field work in which they sought to quantify energy flow across processes and time and energy consumption for shooting, harvesting and farming activities. Most anthropologists have been working in urban and industrial settings where class, race, and location-related environmental issues and health inequities required their attention. Scientific and cultural geographer Charles Good (2000) points out that his career experienced similar shifts from rural and non-Western settings to political economy during the same time.

Epidemiological studies in psychology may help to evaluate the significance of a particular condition in developing medication methods and in preparing special programs for health preventive measures. They may provide documentation on the use of healthcare and the financial impact on the wellbeing-care system of mental illnesses. Observational studies research can also help explain better the mechanism of action of mental illnesses. For instance, when it is figured that in many various nations, based on different cultural and social situations, the incidence rates of anxiety disorders are more or less the same, it seems less likely that these disorders may be linked primarily to cultural or psychosocial affects. If this were the situation, physiological factors that are numerically dispersed among all individuals, regardless of their social economic-cultural environment, must also be seen as the appropriate causative variable (Bandelow & Brown, 2003).

In accordance to Ulijaszek (2013), cognitive anthropology emerged in the American anthropology movement, beginning in the 1950s, to rethink both the idea of interacting with community anthropologists and the ethnography techniques. Cognitive anthropology suggested that anthropology should move away from' culture' interpreted in terms of behavior or objects to community as information structures or mental arrangements. Cognitive anthropologists examine similar and different beliefs within members of a social group, interpret information in specific social contexts, and other cognitive variables such as memory or interpretive devices such as narrative structures. Community systems, community understanding studies, functional perception/distributed thinking and behavioral epidemiology are among the leading fields in cognitive science.

Method and Procedures

From November 2018 and April 2019, the study included 200 people at the health facility called Hearts International Hospital Rawalpindi, who had completed the formal written examination of the clinic. To complete the assessment, both participants had to be legally able, could not be diagnosed with a mental disease or a drug addiction issue, and those who were dating had to be more than five years old to live with their spouse. Given that financial challenges are among the main concerns that have been taken into consideration (Whisman, Dixon, & Johnson, 1997). The use of a clinical survey was thought to improve the likelihood of detecting any economic hardship on respondents. Residents of Rawalpindi or the surrounding region made up the majority of the

responders. Both of them were fluent in Urdu and Punjabi. The average age of the females was 35.66 years (SD = 9.01) while the average age of the males was 38.04 years (SD = 9.07). The majority of women and men (83.4 and 75.9%, respectively) completed high school, with 60.6 percent of women and 44.7 percent of men completing any post-secondary education. Many males (75.4%) and females (82.3%) considered themselves to have religious beliefs. Respondents who were married had been living together for an average of 10.39 years (SD = 7.49). For 79 percent of couples having children, the total number of children was 1.45 (SD = 1.0).

The majority of men (88.0%) were employed, with the majority of them working full-time (74.1 percent). A total monthly personal income of Rs 50,000 or more was reported by half of the women (50.4%) and the majority of the males (72.0%). Males had a somewhat greater average monthly gross income than females. By merging sales, the majority of the couples were in the middle class. However, these findings on each partner's income should be interpreted with caution, as the demographic type's unclear phrasing may have led participants to include both spouses' wages in their personal income estimations. Each member was asked to fill out a questionnaire on their gender, ethnicity, age, salary, profession, schooling, job status, relationship status, years of marriage, number of children in the family, and religion.

In order to calculate the level of depression and anxiety, Hamilton Anxiety and Depression Inventories were used. It was of paramount importance to the experiments carried out during this study to cause reproducible psychological stress. The Hamilton Anxiety Rating Scale (HAM-A) and Hamilton Depression Rating Scale (HDRS17) were used to determine the level of anxiety and depression among the patients that were suffering from cardiovascular disease. The HAM-A test was reviewed by a clinician. The length of administration for HAM-A is quarter of an hour and the core determination were to determine the bleakness of anxiety signs. The measure consisted of 14 items, each identified by a number of indicators, and dealings in psychological nervousness as well as bodily nervousness.

Though the HAM-A is still commonly pre-owned in clinical trials as a product indicator, it has been disapproved for its often-weak ability to distinguish between anti-nervousness and antidrug effects and bodily nervousness versus bodily side effects. Items are rated starting from measure 0 (not existing) to 4 (risky), with sum of total measure between 0-56, having less than seventeen signifying mild severity, slight to reasonable harshness if the measure was between 18-24, and reasonable to stern if the measures were between 25-30 (Hamilton, M, 1959).

The assessment of HDRS17 was also marked as a clinician. The time for HDRS administration is approximately half an hour. The key drive was to determine the harshness and improvement in signs of depression. The HDRS17 was initially established for people admitted in a care facility, hereafter the focus on depression's low and bodily signs. The scoring system varies from version to version. For HDRS17, it is generally accepted that a score of 0–7 is within the standard array, whereas a measure of 20 or advanced is normally mandatory to enter a clinical trial (Hamilton, 1960)

Data Analysis

Increased psychosocial well-being is expressed by the association between reduced wealth differences and improved population wellbeing. Wellbeing is more closely linked to proportional wealth in developed countries compared to absolute wages. The effect on psychosocial well-being of social domination, deprivation, autonomy, and the consistency of social ties is one of the most important reasons for the trend of population wellbeing in rich countries.

Table 1: Gender Frequency

Gender	Frequency	Percentage
Male	84	42.0
Female	116	58.0
Total	200	100.0

Table 2: Marital Status Frequency

Marital Status	Frequency	Percentage
Single	4	2.0
Married	185	92.5
Widow	11	5.5
Total	200	100.0

Table 3: Education Frequency

Education	Frequency	Percentage
Illiterate	86	43.0
Primary	14	7.0
SSC	22	11.0
HSSC	24	12.0
Bachelor	34	17.0
Masters	17	8.5
M.Phil	3	1.5
Total	200	100.0

Monetary values and hardship were required to establish a link between income and health on a personal level. Each step up the social ladder is frequently accompanied with an improvement in health, although one that is deteriorating. To put it another way, there is a gradient at the individual level. In contrast, research into large data sets that monitor people over time in general societies has come to the conclusion that socioeconomic deprivation is associated with lower wellbeing (Blane, Davey Smith, and Bartley 1993). It is possible to develop the "weaker" and "stronger" variations of the psycho-social understanding of how income disparity affects wellbeing. The more powerful version demonstrates that wealth inequality and related psychological dynamics provide a broad explanation and are among the most important predictors of health in both rich and poor nations. In a weaker form, certain health outcomes are linked to wealth disparity and psychological processes. This inferior variation, on the other hand, is impossible to evaluate without first determining which effects are likely to be altered.

Financial stress, psychological aggressive stress, and fear are all linked to maturity, level of education, number of years between partners, relationship status, and the percentage of children living in the community, according to previous study (Howe et al., 2004; Karney & Bradbury, 1995; Waite & Lillard, 1991). Job role did not appear to affect any of the primary factors, and therefore was not measured in this study. The other socioeconomic factors were quantitatively monitored by partial extraction from the path model variables before proceeding with the multivariate analysis since they were tightly connected with at least one of the primary research variables (Newcomb & Bentler, 1988). Each of the demographic factors lowered economic stress, despair, anxiety, and psychological hostility against the spouse.

Stratification is seen by anthropologists as a central characteristic of diverse cultures, and so they take it as a given that health illnesses can be segregated between social classes.

Epidemiologists have assessed the effect of hierarchy on health since the middle of eighteenth century and have applied emphasis to class-based wellbeing inequalities mainly in the UK. Epidemiologists were less interested in income and power in the U.S and were more likely to treat ethnicity or class as influencing variables than as key indicators. Promising markers are the collaborations between anthropologists and epidemiologists involved in exploring at the medical ramifications of inequality. For starters, social epidemiologists summarised the social class health effect evidence and highlighted the many flaws with how it was constructed and analyzed. Medical anthropologists, notably those concerned with contemporary world analyses, conducted epidemiological studies on the health effects of lower socioeconomic inequalities in the U. S. Based on both observational and anthropological data, many social scientists have provided detailed studies of the presents a risk of inequity over time on health.

As noted earlier, it is a significant influence in the evaluation and dealing of persons under financial burden to recognize unease and/or despair as facilitating factors between financial stress and emotional domination. Compatible to other research that find only an unintended correlation between financial stress and undesirable behaviors of partners. Women appear to feel frustrated and nervous under economic pressure, but the fear that contributes to surges not only in their own emotional hostility, but also in that of their partner. On the other hand, while men have become depressed and distressed as they suffer from financial hardship, it is only their despair that completely and substantially leads to the rise in emotional torture of both spouses (Conger et al., 1999, 2002; Kwon et al., 2003).

The participants in this sample showed substantially advanced stages of despair and nervousness than their husbands, as conveyed by others (Eaton & Bradely, 2008). However, there were no substantial variations between men and women in the possibility of reacting to signs of depression and nervousness when experiencing financial pressure. Therefore, gender disparities in levels of nervousness and despair may be due in this study to women enduring slightly developed stages of financial burden. Despair and nervousness were shown to be positively linked in the same relationship and through relationships for both men and women, which confirms the observational evidence that has consistently documented high levels of two diseases between both moods (McCue Horwitz et al., 2007; Mineka et al., 1998). The results of this study also reveal, considering this relationship, that men under economic pressure are slightly more likely to develop despair rather than nervousness. Among women, who can become similarly nervous and irritated as they encounter financial strain, this distinction is absent.

They can be viewed as representing gender disparities in the perceptions of the financial position when all these findings are taken together. The patriarchal system of society has led, from a feminist viewpoint (Antrobus, 2004), to the development of an imbalanced situation between men and women in terms of power over financial capital. The limited opportunities for women to produce an income equal to men due to family care restrictions and the supremacy of men in the labour market reinforce the economic reliance of women on the identity of men and men with the primary role of breadwinner in the family.

In the situation of financial difficulties, because of their limited opportunities to address financial issues (e.g. collecting more revenue) and their decreased capacity to make financial choices, women may be more worried than their husbands (e.g., selling the car). It might also explain why, rather than their despair and pessimism about their financial situation, women's dread stemming from their restricted odds of fixing the complicated problem provokes more personality characteristics towards their male spouse. This belief is supported by a recent study that indicated that a lower feeling of personal autonomy causes the detrimental impact of economic stress on psychological well-being among jobless persons (Creed & Bartrum, 2008). Men, on the other hand,

may feel more sad than concerned about financial concerns due to their perception of being the major person responsible for the couple's finances.

In their ability to serve their principal breadwinning position, males may practice a logic of disappointment, causing them to feel gloomy and disheartened. This sensation of disappointment can be extra severe for men than any fear their economic problems can produce. In addition, the female anxiety generated by her own particular monetary burden may intensify the logic of incapacity of the male to fulfill his financial obligations and, thus, men may respond to their female partner with psychological violence.

As Bandelow & Borwin (2003) demonstrate, in prospective trials, diverse types of mortality rates are assessed, and both have their strengths and weaknesses. The prevalence of life is the proportion of the science that has ever experienced a disease in its probability of life. For diseases with high frequency, high lifespan occurrence values may be overlooked. Longer-term disorders are expected to be overwhelmingly represented as compared to short-term ones in annual incidence rates. The more serious the condition, or the link between the lifetime and 12-month prevalence rate, needs to be found.

Large-scale, expensive, and difficult assessments must be conducted to determine the prevalence of psychiatric illness. A very straightforward way to figure out how many persons suffer from such psychological conditions would be to perform a survey of all people visiting separate facilities for mental wellbeing. In comparison, by actually comparing persons who consult a psychiatrist in a high school or psychiatric institution for panic disorder or severe depression, one would achieve prevalence statistics that could be greatly skewed, since they could be affected by multiple factors such as the profession of the practitioner. In comparison, prevalence patterns may be altered because patients with certain forms of psychiatric conditions, such as patients with bipolar depressive disorder, appear to make increased utilization of medical services, and others, such as patients with extreme anxiety or severe cognitive disabilities, may barely seek psychiatric assistance. Finally, certain people could actually not afford to see a doctor in certain countries, resulting in underestimating the prevalence of such diseases in that population (ibid 2003).

Conclusion

There was no distinct concept of relative income or relative unhappiness at the basis of the psychological awareness. Indeed, determining which group(s) of individuals to compare in order to achieve a sense of relative deprivation is difficult, as is determining whether the health losses associated with an upward contrast with those higher in social rank outweigh the health benefits associated with a descending contrast with those higher in rank. People, not only with those in their immediate region, but also with those who are far more geographically remote, seem inclined to form various connections. Fatalities at work, uncertainty in the workplace and unemployment can be differentially distributed across age, race and gender divisions. Working conditions (including laws on work, susceptibility to sexual harassment and workplace insecurity), exposure to occupational hazards, and the intersections of paid and unpaid labor, in particular, are all implicated in developing discrepancies in gendered wellbeing.

Economic inequalities, illustrated by wages, jobs and domestic labor demands, tend to more widely underpin gender health differences. Health and well-being are influenced greatly by economic class. In addition, gender dynamics that overlaps with family configuration, social stability, and disability further impact economic status, leading to low health status. Differential health impacts of poverty tend to be faced by men and women. Standard mortality rates for persons of color in Britain are higher than those for the general population and when female mortality is considered, the differences are much more evident. Poverty's social and health effects include continued tension that

raises health conditions and low involvement in athletics and school, which is extremely alarming for youth. Children living in poverty are more vulnerable to learning disabilities, language deficits and anti-social behaviour.

Oppression refers to a lack of equal access to social, political, and economic possibilities, as well as exclusion from these areas owing to one's membership in an identified group. Marginalization, economic disadvantage, and gender are all linked, and social exclusion can have negative health repercussions due to low status, culture, gender, talent, or geography. Overall, there is scant evidence supporting a "strong" psychosocial variant of the wealth inequality-health hypothesis that it is a substantial, generalizable factor of population health within or inside affluent nations. However; there may be some consensus for a "weaker" version, whereby income inequality leads to some health consequences in some contexts.

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