ELSEVIER

Journal of Psychosomatic Research 64 (2008) 255–262

Journal of Psychosomatic Research

Original articles

The psychological and social contexts of complaints of abnormal vaginal discharge: A study of illness narratives in India

Vikram Patel[a,b,*], Gracy Andrew[b], Pertti J. Pelto[c]

[a]*London School of Hygiene and Tropical Medicine, London, United Kingdom*
[b]*Sangath, Porvorim, Goa, India*
[c]*University of Connecticut, USA*

Received 13 June 2007; received in revised form 10 September 2007; accepted 23 October 2007

Abstract

Objective: Epidemiological studies have reported strong associations between psychosocial adversity and complaints of abnormal vaginal discharge (AVD) in South Asia. We aimed to explore the mechanism of these associations through qualitative research. **Method:** We carried out serial in-depth interviews with 42 married women with the complaint of AVD who were purposively selected from a sample of 2494 women recruited into a population-based cohort study in Goa, India. The interviews elicited illness narratives of their complaint, focusing on causal attributions and help-seeking behaviors. **Results:** Women explicitly link their personal experiences of social adversity and stress (such as marital problems and heavy workloads) with their complaints of AVD. The complaint of tiredness, a core feature of depressive and somatoform disorders, and complaint of "tension" were commonly associated with AVD through bidirectional causal interpretations. Reproductive events, particularly related to the menstrual cycle and contraception, comprise another set of causal attributions. Many women hold multiple causal attributions. Most women sought health care, both biomedical and traditional, and their narratives indicate reinforcement of their causal attributions by health care providers. However, treatments were often discontinued or changed due to lack of symptomatic relief, side effects, or costs. **Conclusions:** Reproductive health policy and practice must explicitly acknowledge and integrate research findings on psychosocial associations of AVD to promote a holistic and evidence-based approach for this common complaint in women in South Asia.

Keywords: India; Women; Depression; Sexual health; Somatization

Introduction

The high burden of women's reproductive health complaints in Indian populations has been recognized for more than a decade [1]. A series of population-based studies from the 1990s found frequencies of reported abnormal vaginal discharge (AVD), the commonest reproductive complaint, varying from 13% to 57% [2–7]. In biomedical models, complaint of AVD has generally been attributed to reproductive tract infections (RTIs). This has led to the development of a syndromic approach to the management of RTIs, focusing on women's complaints of AVD as the starting point for clinical algorithms [8]. However, studies that utilized gold-standard laboratory diagnostic tests for RTIs have found only weak relationships between women's reports of AVD and RTIs [9,10]. Those studies raised complex questions concerning the reasons why women in such large numbers complain of AVD.

Studies in clinical settings have demonstrated associations between gynecological symptoms and social and psychological factors [11,12]; furthermore, a number of qualitative studies have indicated that women often associate their complaints of vaginal discharge with tiredness and other somatic experiences [13,14]. We have recently completed a population-based cohort study of the relationship between

* Corresponding author. Sangath, Porvorim, Goa, India. Fax: +91 832 2411709.
E-mail address: vikram.patel@lshtm.ac.uk (V. Patel).

0022-3999/08/$ – see front matter © 2008 Elsevier Inc. All rights reserved.
doi:10.1016/j.jpsychores.2007.10.015

psychosocial factors, RTIs, and gynecological morbidity in Goa, India. We hypothesized that a multifactorial framework that incorporated women's social, cultural, biological, and psychological experiences was needed to understand the etiology of the complaint of AVD [15]. Such a framework may be valuable in understanding help-seeking behaviors and in exploring how help seeking may in turn influence women's understanding of their health conditions. We studied the prevalence and incidence, over 12 months, of the complaint of AVD in a sample of 2494 women who consented to participate from among a sample of 3000 randomly selected women. We examined the association of the complaint with a range of biological (infectious and reproductive), psychological (depression and somatoform disorders), and social (gender-based violence and poverty) factors in both cross-sectional [16] and longitudinal [17] perspectives. We found that 14.5% of women reported the complaint at baseline and that 6.9% of the remainder of the sample experienced new events of the complaint during follow-up. Both these analyses supported our multifactorial framework for the etiology of the complaint and, furthermore, emphasized the role of poor mental health and social disadvantage as independent risk factors.

In the present paper, we extend the findings of our quantitative studies through an exploratory qualitative research study carried out with a sample of married women, nested within a larger quantitative research. The primary aim of this study was to describe the illness narratives of women with complaints of AVD, with a particular interest in examining whether their causal attributions mapped on to similar domains as we had found in our epidemiological studies. Thus, some of the women with complaints of AVD whom we selected were also suffering from a common mental disorder (i.e., depressive or anxiety disorder). We were also interested in exploring the role of help-seeking behaviors, their links to their beliefs, and their reactions to health care. We anticipated, based on the hypotheses for our epidemiological study, that two key mechanisms would emerge to explain the complaint: first, that it was a somatoform complaint, so that in keeping with other somatoform complaints, an association with other somatic complaints and psychological symptoms would be expected [18]; and, second, that it was a result of attribution based on an understanding of the social causes and consequences of the complaint.

Method

Setting

The study was carried out in the state of Goa in west India. The state has a population of 1.4 million people, and the most commonly spoken language is Konkani.

The National Family Health Survey of 1998–1999 ranked Goa high on some indicators of reproductive health. Fertility rates were low, with an average of 1.8 children per woman (national average, 2.9); on the other hand, a quarter of women reported AVD, and nearly a fifth of women reported physical maltreatment since the age of 15 years [19].

Sample

The study population lives in the catchment area of the Aldona primary health center in north Goa. The sampling for the quantitative study has been described elsewhere [16,17]. Three thousand women were randomly selected from a sampling frame of 8595 women aged 18–45 years; 2494 women consented to participate. The qualitative study was carried out with 42 women who were purposively selected from the cohort based on the following criteria: (a) ever married; (b) reported complaints of AVD at recruitment (based on their response to a question about discharge experienced in the previous 3 months that the woman considered abnormal on account of its volume, odor, or color), and (c) either Konkani speaking or English speaking. A subgroup of these women was purposively selected because they were also suffering from a depressive or anxiety disorder (often collectively termed as "common mental disorders") [20] based on a cutoff score of 11/12 on the Revised Clinical Interview Schedule, a structured psychiatric diagnostic interview used extensively in previous research in Goa [21,22].

Data collection

The data for the study came from serial in-depth interviews conducted by interviewers who were trained in qualitative methods by the authors, who had experience in this research method (G.A., V.P., and P.J.P.) [13,23–25]. The first interview took place within 2 months of recruitment to the cohort; the second was conducted within 2 months of a 6-month review of the subject. The interviewer had access to the individual women's quantitative data, including their sociodemographic characteristics, reproductive health data, and mental health data, but was not aware of the quantitative findings of the study sample, as the qualitative study was carried out concurrently with the epidemiological study. Interviews were tape recorded after the necessary consent had been acquired. Interviews lasted about 60 min and were mostly conducted in the homes of the women. All interviews were carried out alone; when problems in assuming privacy arose, the interviews were held at the study field center.

Interview themes

Interview themes were developed iteratively, starting with a set of research questions, followed by piloting and role play. The interview guide for the first interview covered the following themes: