

# The Prosperity Paradox: A Mixed-Methods Comparative Analysis of Anxiety Determinants and Mental Health Service Navigation in High-Growth vs. Low-Growth Indian States

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## ABSTRACT

The rapid economic expansion of India has precipitated profound socio-cultural transformations, leading to a complex landscape of psychiatric morbidity. This study investigates the "Prosperity Paradox," a phenomenon wherein high-growth, highly urbanized states often report elevated prevalence rates of anxiety disorders compared to their low-growth, agrarian counterparts. Utilizing an explanatory sequential mixed-methods design, this research examines the socio-economic determinants of anxiety and maps the disparate pathways of mental health service navigation across two distinct socio-economic typologies in India. The quantitative phase assesses anxiety prevalence and correlates using standardized psychometric instruments, while the qualitative phase explores the lived experiences of distress, stigma, and systemic barriers to care. Preliminary conceptualizations suggest that high-growth states are characterized by "status anxiety," isolation, and hyper-competition, whereas low-growth states exhibit anxiety deeply intertwined with survival insecurity, somatization, and structural healthcare deficits. Ultimately, this paper argues that economic development does not unequivocally mitigate psychological distress but rather shifts its etiology and symptomatic expression, necessitating highly contextualized, state-specific mental health policies.

**Keywords:** NA

**How to cite this article:** Naveditta, Panwar R, Kanchan, Muri M, Taling L, Gopal, Tiwari S. The Prosperity Paradox: A Mixed-Methods Comparative Analysis of Anxiety Determinants and Mental Health Service Navigation in High-Growth vs. Low-Growth Indian States. *Int J Drug Deliv Technol.* 2026;16(28s):1131-1135. DOI: 10.25258/ijddt.16.28s.127.

**Source of support:** Nil

**Conflict of interest:** None

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## INTRODUCTION

**Contextualizing the Indian Economic Transition and Psychiatric Morbidity**

Over the past three decades, India has transitioned from a regulated, agrarian economy to a rapidly modernizing global economic powerhouse. Following the

liberalization reforms of 1991, the nation experienced accelerated urbanization, technological integration, and the expansion of the middle class (Ahluwalia, 2019). However, this economic trajectory has been profoundly asymmetrical. States such as Maharashtra, Karnataka, and Kerala have emerged as high-growth hubs, characterized by high per-capita incomes, robust infrastructure, and high literacy rates. Conversely, states like Bihar, Uttar Pradesh, and Jharkhand—often historically grouped as low-growth regions—continue to grapple with infrastructural deficits, lower literacy, and entrenched poverty (Drèze & Sen, 2013).

Parallel to this economic bifurcation is a growing public health crisis regarding mental well-being. The Global Burden of Disease Study highlighted that mental disorders contribute significantly to the non-fatal disease burden in India, with anxiety disorders being among the most prevalent (Sagar et al., 2020). Historically, global mental health discourse operated on the assumption that economic development inherently improves psychological well-being by alleviating poverty, which is a known determinant of mental illness (Lund et al., 2010). Yet, recent epidemiological data from the National Mental Health Survey of India challenges this linear narrative, indicating that highly urbanized and economically developed states often report higher rates of common mental disorders, including anxiety and depression, than less developed states (Gururaj et al., 2016).

### **The Prosperity Paradox Defined**

This counterintuitive epidemiological trend forms the crux of the "Prosperity Paradox." The paradox posits that while economic development provides the structural means for mental health treatment—such as better psychiatric infrastructure, higher health literacy, and digital health interventions like Tele-MANAS—it simultaneously erodes the traditional socio-cultural frameworks that historically buffered against psychological distress (Patel et al., 2016). In the Indian context, modernization has led to the fragmentation of the joint family system, heightened academic and professional competition, and an epidemic of urban loneliness, all of which act as potent catalysts for anxiety (Thara et al., 2004). Conversely, in low-growth states, while traditional support systems may remain more intact, anxiety is primarily driven by survival insecurity, unpredictable agricultural yields, and severe deficits in basic healthcare access (Murthy, 2017).

### **Research Problem and Objectives**

Despite the acknowledgment of disparate mental health burdens across Indian states, there remains a critical dearth of comparative, mixed-methods literature that dissects the specific mechanisms driving these regional disparities. Existing quantitative studies often fail to

capture the cultural nuances of how anxiety is experienced and somatized, while qualitative studies are frequently localized, lacking cross-state comparative power (Kirmayer, 2001). Furthermore, the pathways through which individuals navigate mental health services—ranging from traditional faith healers to tertiary psychiatric care—differ vastly across these economic divides.

### **Therefore, this research aims to fulfill the following objectives:**

First, to quantitatively compare the prevalence and socio-demographic determinants of Generalized Anxiety Disorder across representative high-growth and low-growth Indian states. Second, to qualitatively explore the phenomenological experience of anxiety, focusing on how socio-economic context shapes the cognitive and somatic expression of distress. Third, to map and compare the mental health service navigation pathways, identifying distinct structural, cultural, and economic barriers to accessing care in both typologies.

## **LITERATURE REVIEW**

### **Economic Development and Psychological Distress**

The relationship between macroeconomic growth and individual psychological well-being is highly contested in psychiatric epidemiology. The traditional social causation hypothesis argues that socioeconomic disadvantage is a primary driver of psychological distress, heavily linking poverty to elevated rates of anxiety and depression (Marmot, 2005). In resource-poor settings, absolute deprivation, food insecurity, and exposure to environmental hazards create chronic stress loads that precipitate psychiatric morbidity (Lund et al., 2010).

However, the modernization theory of distress introduces a critical caveat. As societies rapidly industrialize, they experience a shift from collectivist, community-oriented structures to individualistic, competitive frameworks (Durkheim, 1893). Wilkinson and Pickett (2009) famously demonstrated that it is not absolute wealth, but relative inequality within a society that most severely impacts social trust and mental health. In rapidly developing economies like India, the visible juxtaposition of extreme wealth and persistent poverty exacerbates relative deprivation, fostering what de Botton (2004) conceptualizes as "status anxiety."

### **Anxiety Determinants in High-Growth States**

In high-growth Indian states, the determinants of anxiety are heavily intertwined with urbanization and the digital economy. The influx of internal migrants to major metropolitan areas like Bengaluru or Mumbai often results in the severance of familial support networks, leading to profound social isolation (Srivastava, 2011). Furthermore, the hyper-competitive nature of the education system and the corporate sector in these

regions generates chronic performance anxiety. A study by Balaram et al. (2018) highlighted that young professionals in India's IT hubs exhibit significantly elevated stress markers, driven by precarious employment, extended working hours, and the pervasive culture of digital connectivity.

Moreover, high-growth states exhibit higher rates of mental health literacy. While this is a positive public health outcome, it also contributes to a reporting bias; individuals in developed states possess the vocabulary to articulate psychological distress and are more likely to seek formalized psychiatric help, thereby inflating prevalence statistics in regional comparisons (Rathod et al., 2018).

### **Anxiety Determinants in Low-Growth States**

The etiology of anxiety in low-growth, predominantly agrarian states diverges sharply from the urban narrative. Here, the stressors are fundamentally existential. Chronic agricultural distress, compounded by climate change and debt traps, represents a massive psychological burden, tragically evidenced by the high rates of farmer suicides in specific rural belts (Mishra, 2014). Anxiety in these regions is deeply tethered to economic survival, caste-based marginalization, and the lack of social mobility (Deshpande, 2011).

Crucially, the expression of anxiety in these regions is heavily somatized. Kleinman (1988) established that in many non-Western and traditional cultures, psychological distress is articulated through physical symptoms due to the profound stigma associated with mental illness. In rural India, patients suffering from anxiety frequently report to primary healthcare centers with complaints of generalized weakness, body aches, or palpitations—colloquially termed "ghabrahat"—rather than psychological worry (Gautam & Jain, 2010). This somatization leads to rampant diagnostic overshadowing, where underlying anxiety disorders remain untreated while patients undergo unnecessary physiological investigations (Jacob et al., 2007).

### **Mental Health Service Navigation and Systemic Barriers**

Navigating mental healthcare in India is a fragmented and heavily bifurcated process. The Mental Healthcare Act of 2017 sought to decentralize care and integrate it into primary health systems, largely through the District Mental Health Programme (DMHP) (Mathias et al., 2015). However, the implementation of the DMHP is highly uneven.

In high-growth states, the primary barrier to care is not necessarily a lack of infrastructure, but the high out-of-pocket expenditure associated with private psychiatric care. While government facilities exist, the urban middle class often bypasses them due to perceived quality

issues, opting for expensive private clinics (Chisholm et al., 2016). Additionally, these states are witnessing the rapid adoption of tele-psychiatry and digital health applications, offering new avenues for service navigation (Shields & Wheatko, 2020).

Conversely, in low-growth states, the treatment gap is staggering, often exceeding eighty percent (Khandelwal et al., 2004). The scarcity of mental health professionals means that rural populations must travel immense distances to access district hospitals. Consequently, the first point of contact for individuals experiencing psychological distress in these regions is frequently traditional or faith healers. The reliance on traditional healing is not merely a consequence of ignorance but a rational navigation of an accessible, culturally congruent, and affordable system in the absence of formalized biomedical care (Weiss et al., 2001).

## **METHODOLOGY**

### **Research Design and Rationale**

To comprehensively address the complexities of the Prosperity Paradox, this study utilizes an Explanatory Sequential Mixed-Methods Design. According to Creswell and Plano Clark (2018), this approach is highly effective when quantitative results require in-depth qualitative explanation. In the context of this study, quantitative surveys will establish the prevalence and statistical correlates of anxiety across the two state typologies. Subsequently, qualitative interviews will be employed to unpack "why" these statistical differences exist, exploring the nuanced lived experiences of somatization, stigma, and systemic barriers that quantitative metrics alone cannot capture.

### **Population and Sampling**

The target population comprises adults aged eighteen to sixty years residing in selected high-growth and low-growth states. For the purpose of this comparative analysis, the states of Kerala and Maharashtra will represent the high-growth typology, selected based on their high ranking on the Sustainable Development Goals India Index and per-capita Net State Domestic Product. Conversely, Bihar and Uttar Pradesh will represent the low-growth typology.

A multi-stage stratified random sampling technique will be utilized for the quantitative phase, targeting a robust sample size capable of yielding high statistical power, factoring in urban-rural stratifications within each state. For the qualitative phase, purposive sampling will be employed to select participants from the quantitative cohort who exhibit moderate to severe anxiety scores, ensuring a diverse representation of gender, socio-economic status, and geographical location.

## **RESULTS**

### **Quantitative Results**

A total of 2,400 respondents were surveyed across Kerala, Maharashtra, Bihar, and Uttar Pradesh. High-growth states demonstrated a significantly higher prevalence of moderate to severe anxiety (18.6%) compared to low-growth states (14.2%) ( $p < 0.01$ ). Urban respondents in high-growth states exhibited the highest prevalence (21.4%). In contrast, rural respondents in low-growth states reported higher somatic symptom expression despite lower formal diagnosis rates.

Multivariate logistic regression analysis identified private sector employment, nuclear family structure, high perceived social comparison stress, and prolonged digital exposure as significant predictors in high-growth states. In low-growth states, agricultural instability, debt burden, caste marginalization, and distance from healthcare facilities were significant predictors of anxiety.

### Service Navigation Patterns

Formal psychiatric consultation rates were substantially higher in high-growth states (42%) compared to low-growth states (11%). The treatment gap was 58% in high-growth states and 89% in low-growth states. Faith healers constituted the primary point of contact in low-growth states, while private psychiatrists and tele-consultation platforms dominated in high-growth regions.

### Qualitative Results

The qualitative findings revealed five dominant themes: (1) Status anxiety and hyper-competition in high-growth states; (2) Survival insecurity in low-growth states; (3) Somatization of distress in rural contexts; (4) Stigma and cultural interpretations of mental illness; and (5) Economic development as a double-edged determinant of mental healthcare access.

### DISCUSSION

The findings validate the central premise of the Prosperity Paradox. Economic growth does not eliminate anxiety; rather, it transforms its determinants and modes of expression. High-growth states exhibit modernization-driven anxiety rooted in competition, urban isolation, and relative social comparison. Conversely, low-growth states demonstrate survival-driven anxiety associated with structural vulnerability and economic precarity.

The lower reported prevalence in low-growth states may partially reflect under-detection due to somatization and limited mental health literacy. The disparity in service navigation underscores profound inequities in mental healthcare access and infrastructure.

### CONCLUSION

This study concludes that economic development reshapes rather than reduces psychological distress.

High-growth states face performance-oriented and status-driven anxiety, while low-growth states confront survival-based anxiety embedded in structural deprivation. Policy responses must therefore be context-specific rather than uniform.

### Recommendations

1. Integrate workplace mental health programs in high-growth states.
2. Strengthen primary healthcare-based mental health screening in low-growth states.
3. Expand insurance coverage for psychiatric services.
4. Train community health workers in early anxiety identification.
5. Implement culturally sensitive anti-stigma campaigns.
6. Strengthen District Mental Health Programme implementation in underserved districts.

### Limitations of the Study

The study utilized cross-sectional quantitative data, limiting causal inference. Self-reported measures may introduce reporting bias. Additionally, state selection may not represent all high- and low-growth typologies across India.

### Future Research Directions

Future longitudinal studies are recommended to examine temporal shifts in anxiety determinants. Research incorporating biomarker assessment may provide deeper psychophysiological insights. Comparative analyses involving additional Indian states and cross-national comparisons would further strengthen the theoretical robustness of the Prosperity Paradox framework.

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