O R I G I N A L P A P E R

Age and Gender as Determinants of Psychological Health for Roma People in Greece

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Abstract

The purpose of this article is to study the psychological characteristics of Roma people in Greece focusing in the particular relation of age and gender with shame and psychopathology. The Others as Shamer scale, Experience of Shame Scale and Symptom Check List 90 were administered to collect the data along with a detailed questionnaire which recorded all social and economic factors that may affect the psychological characteristics studied. Participants were 361 Romani people (236 women and 125 men), living in the central Greece area. Data collection took place between January 2011 and December 2012 and interview was chosen as the appropriate way of data collection. We find that Romani women endorsed higher psychological distress than men at all the symptoms domains encountered: general psychopathology, anxiety, depression and shame. Further, they suffer from inadequate health care and housing conditions, poor quality of education, and lack of job opportunities. Young women Roma are more educated and they do not have high levels of psychological distress as older persons do. Interventions to improve the health status of Romani women should address gender and ethnic inequalities simultaneously, whereas educational programs should be addressed to older persons of Roma community as well.

Keywords*:* Women, Shame, Roma, Psychology, Disparities

Introduction

Historically, the Roma population has been one Europe's most marginalized and persecuted minorities. Romani people in Greece, as elsewhere in Europe, are stereotyped as illiterate, sly, lazy and irresponsibly while Romani women are considered to burden the state by bearing too many children, too early, and too often. A major reason for this alienation of this people in all the places they stay is the different way that they perceive health and illness. In Roma worldview health and illness are usually attribute to good and bad fortune, purity and impurity, and inclusion or exclusion from the group. These concepts affect everyone's life, including the way Roma people deal with birth and death, eating habits and personal cleanliness, physicians and hospitals, the diagnosis and the cure of illness. Due to the great differences in perception of life an observer should be careful when approaching the issue of whether women are more oppressed and more abused than men in Roma communities, since a treatment that would have been perceived by an observer as humiliating and degrading is actually accepted by the women themselves, as an undeniable social norm although well known and established psychological scales offer a valuable tool to resolve this difficulty.

A clear reality is that the Roma minority occupy the lowest position in terms of education, employment, housing and health care. Many Roma are not entitled to public health care and social welfare. In particular, it is not known how many Roma babies

are born in hospital maternity wards and how many in the slums. Many are probably delivered by old Roma women. It is not a surprise that life expectancy of Roma communities in all European countries is shorter than the European average (European Union: Public Health Programme, 2009).

While research on the social and economic data the Roma community is rich, this is not true for health problems, in particular for mental health. A possible explanation for this lack of information is the widespread prejudices and unconscious avoiding force that supports them, affecting among others the scientific community. (Maciejewski, 1994)

Although the research on Roma minority seems to be underdeveloped, there are reports from most areas where Roma resides focusing on the cultural specificities and the obvious need to understand them, in order to promote hygiene and solve the acute health problems they present, but also finding that health professionals who dealt with the matter reaches in deadlocks and embarrassment when facing this population as patients (Sutherland A., 1992). Interventions characterized from sensitivity to the cultural peculiarities of this people are the most successful initiatives. (Ojanlatva, et al., 1997, Vivian, 2004).

Aim of this article is to study of psychological health of Roma focusing especially in gender disparities in the community and evolution of psychopathology and shame over age contributing this way to a subject which has not been addressed in extent in the literature.

Method

Participants and study design.

The data collection was carried out between January 2011 and December 2012. Five hundred Romani people was initially communicated from the researcher and 361 finally responded, 236 women (65.4%) and 125 men (34.6%), aged 14 to 73 (M= 34.0, SD 12.8). The majority of the respondents were living in Larissa prefecture (230 respondents, 63.7%), while 128 (35.5%) did not declare their permanent residence. Two hundred seventy one were married (75.1%), whereas 62 (17.2%) were single and 28 (6.8%) in other marital status (divorced, widowed, separated). The demographic characteristics of the participants along with the statistical significance of the gender differentiation are summarized in Table 1.

Although the precise level of representativity of this sample for the entire population of Romani people in Greece cannot be estimated, the consistency and accuracy of data is ensured by the relatively large size of the sample (361 respondents).

Instruments and measures

The first part of the questionnaire gathers basic information from the respondent: sex, age, labour situation, type of healthcare coverage, difficulties encountered in everyday life, disability or chronic disease, etc. This part of the questionnaire also gathers information common to all members of a household: number of people in the household, habitual caretaker of minors, type of home, type of neighbourhood and whether social and health services are available in the area. To study further the respondent's psychological profile, the following instruments were used:

Others as Shamer *(OAS; Goss et al., 1994).* This 18 items scale measures external shame (global judgements of how people think that others view them). Respondents rate on a 5-point Likert scale (0–4) the frequency of their feelings and experiences in items such as 'I feel other people see me as not quite good enough' and 'I think that other people look down on me'. Higher scores on this scale reveal high external shame. The Greek version of OAS questionnaire - has been validated by Gouva et al (2014) - and found to have an excellent internal consistency (Cronbach's $\alpha = 0.944$).

Experience of Shame Scale *(ESS; Andrews et al., 2002).* ESS is a 25-item scale assessing feelings of shame around three key domains of self: character (personal habits, manner with others, what sort of person you are and personal ability), behaviour (shame about doing something wrong, saying something stupid and failure in competitive situations) and body (feeling ashamed of one's body or parts of it). Each item indicates the frequency of experiencing, thinking and avoiding any of the three areas of shame in the past year and is rated on a 4-point Likert scale (1–4). The Greek version of ESS questionnaire have been translated and validated into Greek by members of the research team (Gouva et al., 2014). In the present study, ESS total score showed an excellent internal consistency (Cronbach's $\alpha = 0.935$).

Symptom Check List 90 *(SCL-90-R) (Derogatis, 1983).* The SCL-90-R was used to assess mental well-being. This widely used screening tool, which can be used for screening against putative cases of psychiatric/psychological illness, contains 90 items with a 5-point scale (0 = not at all, 4 = extremely), and assesses symptomatology in nine areas

(*Somatization - SM, Obsessive–Compulsive - OC, Interpersonal Sensitivity - IS, Depression - DR, Anxiety - AN, Aggression - AG, Phobia - PH, Paranoid Ideation - PI, Psychoticism - PS*).

The average score of all 90 items yields the global severity index (GSI), which represents the overall level of distress and suggested to be the best single indicator of the current level of the disorder (Derogatis, 1983). Higher scores on the scales of the SCL-90-R indicate higher distress, however it should be noted that individual scales cannot be interpreted in diagnostic categories.

Statistical analysis

All data were analysed using predictive analytics software (SPSS), version 20 (SPSS Inc., Chicago, IL, USA). The OAS, ESS – 25 and SCL-90-R were scored and analysed according to the published guidelines using appropriate compute and transform commands on SPSS application while Cronbach's a was computed for every subscale.

For better interpretation of the results, a second variable was created for age where each participant was identified by the corresponding age quartile (1 to 4). This age variable was used in subsequent analysis instead of age.

Multiple analysis of variance (MANOVA) was conducted to explore whether gender, age and education (graduation or not from primary school) have an effect on the group of global severity index (GSI), experience of shame total score (ESS) and others as shamer total score (OAS).

We choose to apply MANOVA instead of three ANOVA's since MANOVA takes into account the intercorrelations among the dependent variables while reduce the experiment-wise level of Type I error.

The chi-square test of independence was performed to examine the relation between pairs of nominal or ordinal variables whereas Fisher exact test was applied when the necessary assumptions for chi square was not met.

Independent samples t test were conducted to explore whether there are differences between the groups defined by dichotomous variable for all scales that were computed from our data. In every replication of the method Levene test was used to test whether equality of variances is assumed and Welch's t test was applied instead when this necessary assumption was not met. Analysis of variance was applied to explore whether there are differences between the groups defined by age category for all scales that were computed from our data. Homogeneity of data was verified for each replication of the method.

A two sided level of significance was set at 0.05 for all statistical tests except univariate statistical test that followed at MANOVA where 0.05 was divided the number of tests we performed, that is for that particular tests we required that $p < .05/3 = .017$.

Results

Substantial number of Romani households lives in the substandard housing conditions characterized by insufficient access to cooking facilities (89 respondents, 24.7%) or sanitation (89 respondents, 24.7%).

The respondents, in their majority (n = 266, 73.7%) did not finish primary school (187 women, 79.2% and 79 men, 63.2%), while women were statistically more likely to be illiterate (OR = 2.2, 95% C.I. 1.33 – 3.69, $p < .001$). A worth noting remark is that the difference is not statistically significant in the younger half of the sample, in particular in ages 14 – 23 ($c^2(1, n = 361) = 0.259$, $p = .611$) and 24 – 31 ($c^2(1, n = 361) = 0.858$, $p = .354$) (Figure 1).

Further, among respondents that has attended primary school, the total duration of school attention was not statistically different between women and men ($M_w = 6.7$ school years, $M_m = 6.4$, $t(93) = 0.907$, $p = .367$).Women have inferior employment profile in comparison with men. In particular, only 3.8% of them possess a permanent position, 22.8% are seasonal employment, 70.4% of them are not working and 3% are retired. On the other hand, 16% of the men possess a permanent position, 33.6% are seasonal workers, 34.4% are unemployment and 11.2% are retired. The dependency of gender with employment type is statistically significant ($c^2(5, n = 361) = 77.828$, $p < .001$). Furthermore, the Romani women that are working receive substantially lower payments for their work than Romani men (308€ vs. 385€, $t(144) = 2.848$, $p = .005$).

The majority of respondents (N = 305, 84.5%) belong in a family with at least one member suffer from a chronic psychosomatic illness while 122 of them (33.8%) had themselves a chronic illness (84 women, 38 men); gender had a non significant effect on that proportion ($c^2(1, n = 361) = 0.985$, $p = .321$). It is worth noting that among the 84 women that had a chronic illness only 13 (15.5%) of them had a doctor systematically monitoring them while 9 (23.7%) of the 38 male respondents with chronic illness did so.

Table 1 : Demographic and clinical characteristics of respondents

	Total	Female (N = 236)	Male (N = 125)	*p**
Age, mean ± SD	34.0 ± 12.8	33.3 ± 12.7	35.3 ± 12.8	.157
Marital status, N (%)				.241
Single	62 (17.2%)	41 (17.4%)	21 (16.8%)	
Married	271 (75.1%)	173 (73.3%)	98 (78.4%)	
Divorced	14 (3.9%)	13 (5.5%)	1 (0.8%)	
Widowed	10 (2.8%)	7 (3.0%)	3 (2.4%)	
Separated	4 (1.1%)	2 (0.8%)	2 (1.6%)	
No of children, mean ± SD	3.4 ± 1.8	3.4 ± 1.8	3.4 ± 1.8	.692
No of siblings, mean ± SD	5.5 ± 2.4	5.5 ± 2.4	5.5 ± 2.4	.243
Unemployed, N (%)	138 (38.2%)	95 (40.3%)	43 (34.4%)	.276
Insurance, N (%)	339 (93.9%)	220 (93.2%)	119 (95.2%)	.636
Use of health services, N (%)	229 (63.4%)	161 (68.2%)	68 (54.4%)	**.009**
No of subjects with chronic psychosomatic illness, N (%)	122 (33.8%)	84 (35.6%)	38 (30.4%)	.321
Education, N (%)				**.004**
None	266 (73.7%)	187 (79.2%)	79 (63.2%)	
Primary	83 (23%)	42 (17.8%)	41 (32.8%)	
Secondary	12 (3.3%)	7 (3.0%)	5 (4.0%)	
Housing, N (%)				.293
Apartment	85 (23.5%)	51 (21.6%)	34 (27.2%)	
Detach house	192 (53.2%)	128 (54.2%)	64 (51.2%)	
Camp	44 (12.2%)	33 (14.0%)	11 (8.8%)	
Other	39 (10.8%)	23 (9.7%)	16 (12.8%)	
Housing details				
Ownership, N (%)	241 (66.8%)	241 (66.8%)	241 (66.8%)	.975
Residents, mean ± SD	7.0 ± 3.3	7.0 ± 3.1	6.9 ± 3.6	.907
Rooms, mean ± SD	2.6 ± 1.4	2.6 ± 1.4	2.5 ± 1.3	.635
Cooking facilities, N (%)	281 (77.8%)	178 (75.4%)	103 (82.4%)	.129
Sanitation facilities, N (%)	272 (75.3%)	173 (73.3%)	99 (79.2%)	.216

(*) Statistical significance of the corresponding test (Independent samples t –test or Chi square)

Table 2 : Pearson Correlations

	OAS	ESS	SM	OC	IS	DR	AN	AG	PH	PI
ESS	,660(**)									
SM	,327(**)	,481(**)								
OC	,420(**)	,554(**)	,814(**)							
IS	,640(**)	,656(**)	,595(**)	,721(**)						
DR	,351(**)	,502(**)	,785(**)	,841(**)	,693(**)					
AN	,373(**)	,503(**)	,852(**)	,819(**)	,657(**)	,871(**)				
AG	,396(**)	,469(**)	,558(**)	,604(**)	,561(**)	,509(**)	,627(**)			
PH	,406(**)	,502(**)	,683(**)	,721(**)	,646(**)	,767(**)	,769(**)	,455(**)		
PI	,369(**)	,382(**)	,340(**)	,461(**)	,578(**)	,442(**)	,395(**)	,469(**)	,313(**)	
PS	,415(**)	,602(**)	,726(**)	,731(**)	,626(**)	,734(**)	,765(**)	,518(**)	,742(**)	,442(**)

** Correlation is significant at the 0.01 level (2-tailed).

Table 4: Summarized results of multiple analysis of variation.

Characteristic	GSI	ESS	OAS
Age category	↑	ns	ns
Gender	Female > Male	Female > Male	Female > Male
Education	Ns	Illiterate > Primary School	Illiterate > Primary School

ns: Not significant difference

Table 3 : Descriptive and internal consistency statistics of the SCL-90, ESS, OAS scales (α=Cronbach's α)

Scale	Total	α	Female (N = 236)	Male (N = 125)	<=23 (N = 96)	24 – 31 (N = 89)	32 – 43 (N = 86)	>=44 (N = 90)
GSI	1.1 (0.65)	0.977	1.2 (0.68)	0.8 (0.51)**	0.8 (0.42)	0.9 (0.52)	1.1 (0.68)	0.4 (0.77)**
SM	1.0 (0.84)	0.913	1.2 (0.86)	0.8 (0.76) **	0.6 (0.49)	0.8 (0.6)	1.1 (0.88)	1.6 (0.99)**
OC	1.3 (0.78)	0.855	1.4 (0.79)	0.9 (0.64) **	0.9 (0.58)	1.1 (0.65)	1.4 (0.84)	1.6 (0.84)**
IS	1.3 (0.73)	0.794	1.5 (0.69)	0.9 (0.63) **	1.1 (0.67)	1.2 (0.62)	1.2 (0.76)	1.5 (0.81)*
DR	1.1 (0.85)	0.913	1.3 (0.86)	0.7 (0.66) **	0.8 (0.62)	0.9 (0.76)	1.1 (0.84)	1.5 (0.98)**
AN	0.9 (0.86)	0.910	1.1 (0.91)	0.7 (0.68) **	0.6 (0.58)	0.8 (0.79)	1.1 (0.88)	1.4 (0.97)**
AG	1.0 (0.78)	0.818	1.1 (0.82)	1.0 (0.72)	0.8 (0.75)	1.0 (0.67)	1.2 (0.85)	1.2 (0.81)*
PH	0.8 (0.8)	0.850	0.9 (0.85)	0.4 (0.54) **	0.6 (0.62)	0.7 (0.68)	0.8 (0.86)	1.0 (0.94)**
PI	1.8 (0.69)	0.624	1.9 (0.67)	1.6 (0.7)*	1.6 (0.68)	1.7 (0.72)	1.8 (0.62)	1.9 (0.69)*
PS	0.6 (0.56)	0.790	0.7 (0.61)	0.4 (0.4) **	0.4 (0.37)	0.5 (0.45)	0.7 (0.63)	0.9 (0.67)**
ESS_t	48 (14.1)	0.935	51 (14.5)	41.7 (11.1) ****	43 (13.1)	46 (12.1)	50 (14.7)	52 (15.0)**
CS	21.1 (7.6)	0.912	22.5 (7.8)	18.6 (6.6) **	18.6 (6.5)	19.7 (6.0)	22.5 (8.3)	23.9 (8.4) ****
BHS	19.8 (6.1)	0.897	20.7 (6.1)	18.0 (5.6) ****	18.4 (6.1)	19.8 (5.9)	20.3 (6.3)	20.6 (5.7)
BOS	7.0 (3.1)	0.839	8.0 (3.2)	5.1 (1.9) ****	6.3 (2.9)	6.7 (3.0)	7.5 (3.1)	7.7 (3.3)*
OAS_t	29 (15,1)	0.944	32 (15.1)	22.5 (13.7) ****	27 (15.0)	27 (13.5)	31 (15.4)	32 (15.9)*
INF	12.2 (6.4)	0.908	13.2 (6.5)	10.3 (5.9) ****	11.6 (6.6)	11.6 (6.0)	12.6 (6.2)	13 (6.7)
EMT	5.4 (3.8)	0.782	6.2 (3.8)	3.8 (3.3) ****	4.7 (3.6)	4.8 (3.5)	5.9 (3.9)	6.3 (3.9)*
MIS	10.1 (5.3)	0.843	10.9 (5.2)	8.6 (5.3) ****	9.1 (5.1)	9.5 (5.0)	10.8 (5.3)	11.1 (5.6)*

GSI: Global severity index (SCL-90), SM: Somatization, OC: Obsessive–Compulsive, IS: Interpersonal Sensitivity, DR: Depression, AN: Anxiety, AG: Aggression, PH: Phobia, PI: Paranoid Ideation, PS: Psychoticism

ESS_t: Total ESS score, CS: Characterological shame, BHS: Behavioral shame, BOS: Bodily shame

OAS_t: Total OAS score, INF: Inferior, EMT: Empty, MIS: Mistakes

**: p< .001, *: p< .05

Figure 1 Percent of women (n = 236) and men (n = 125) that have attended primary school by age category.

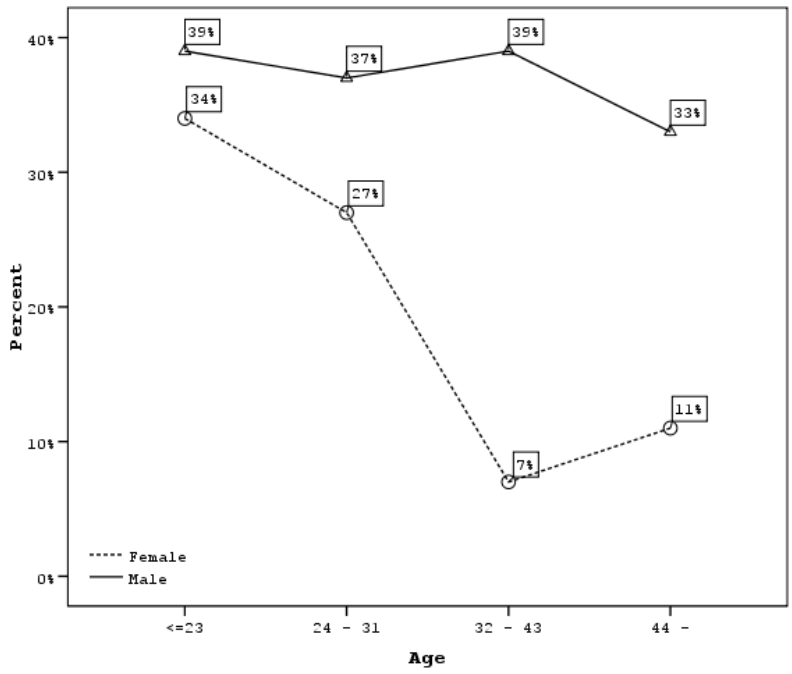
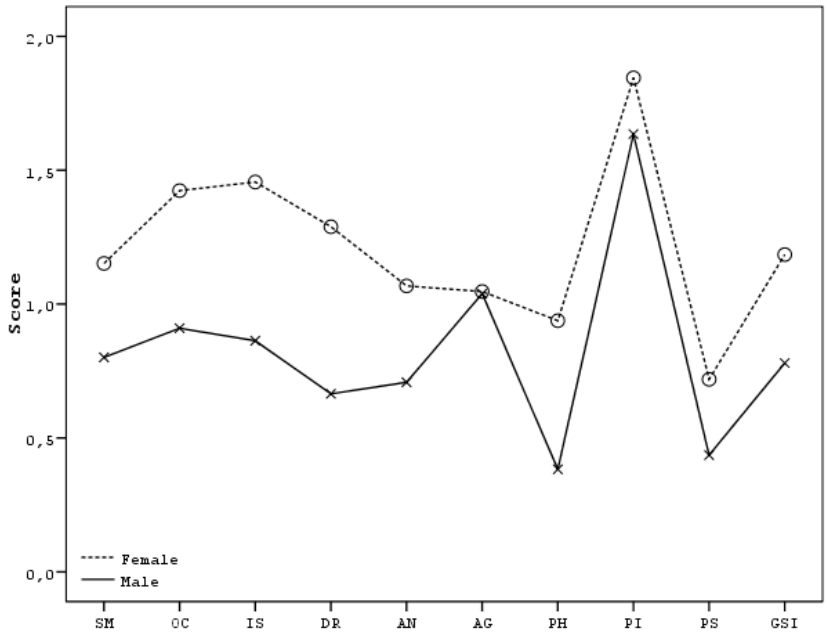


Figure 2 Mean SCL-90 scores of Romani women (n=236) and men (n=125).



Among the 84 women that suffer from chronic illnesses 22 (26.2%) were consulting a physician, 16 (19.0%) a psychologist, and 9 (10.7%) a general practitioner. On the other hand among 38 men with chronic illnesses, 13 (34.2%) were consulting a physician, 6 (15.8%) an orthopaedic doctor and 6 a general practitioner. Romani women were more likely to use public health facilities ($c^2(1, n = 361) = 6.729$, $p = .009$), probably due to the the reproductive process (3.45 children per women, SD = 1.83).

Determinants of psychological health

Romani women had statistically larger scores in all aspects of psychopathology and shame (Table 3 and Figure 2). The aggression subscale was the exception to the rule since men's and women's scores were statistically equal. Age was positive related to the observed scores in all subscales of symptom check list as well as the shame subscales with the exceptions of behavioral and inferior subscale.

As expected, all aspects of psychopathology and shame that was encountered in our study were highly positive correlated (Table 2).

A one-way MANOVA examined GSI, OAS and ESS as dependent variables, and age category, gender and graduation of primary school as independent variables. We found a significant multivariate main effect for the respondents age category (Wilks' $\lambda = .897$, F (9, 832.489) = 4.211, $p < .001$, partial eta squared = .035, power = .987), the respondents gender (Wilks' $\lambda = .931$, F (3, 342) = 8.495, $p < .001$, partial eta squared = .069, power = .994) and graduation of primary school (Wilks' $\lambda = .942$, F (3, 342) = 7.013, $p < .001$, partial eta squared = .058, power = .980). Total variation of the total ESS scale explained from the model was $R^2 = 0.252$ ($R^2_{adj} = 0.219$), while for total OAS scale was $R^2 = 0.163$ ($R^2_{adj} = 0.127$) and for global severity index (GSI) was $R^2 = 0.272$ ($R^2_{adj} = 0.241$).

Given the significance of the overall test, the univariate main effects were examined. Significant univariate main effects for age category were obtained for GSI, (F (3, 344) = 10.957, p <.001, partial eta squared = .087, power = .999), while ESS and OAS score did not induced significant differentiations among age category groups (ESS: F (3, 344) = 3.395, p =.018 > .017 = .05 / 3 and OAS: F (3, 344) = 0.827, p =.480). Gender had a significant effect for GSI, (F (3, 344) = 18.564, p <.001, partial eta squared = .051, power = .990), total ESS score (F (3, 344) = 19.587, p <.001, partial eta squared = .054, power = .993), and total OAS score (F (3, 344) = 5.875, p =.016 < .017, partial eta squared = .017, power = .676). Graduation from primary school had no significant effect for GSI, (F (3, 344) = 0.329, p =.566) while had a significant effect on total ESS score (F (3, 344) = 11.986, p =.001, partial eta squared = .034, power = .932), and total OAS score (F (3, 344) = 16.808, p <.001, partial eta squared = .047, power = .983). We summarize the above results in the table 4.

Discussion

Roma are discriminated against across Europe and have a significantly worse health and education profile when compared with non-Roma (Milcher, 2006, Holt, 2005, Rechel, et al., 2009). Poor education is reflected directly to the health situation of those people: it has been reported that the immunisation coverage of Roma children is low, with lack of information and medical identification being the most common reasons for this (Milcher., 2006, Hajioff &, McKee, 2000, Ringold, Orenstein & Wilkens, 2005).

Focusing in gender differences, this study confirms that Romani women experience lower achievement in education than Romani men and non-Romani women (as state data demonstrates), with no significant progress over the years. They are also less engaged in formal employment and consequently more financially dependent from men. Romani household's members are living in poor housing conditions that are detrimental for their health; women are more exposed to the risk as they stay more at home. Thus, it is come as not a surprise the fact that Romani women endorsed higher psychological distress than men across multiple symptoms domains: general psychopathology, anxiety, depression and self-esteem. Many are in need of psychological support, and although they probably feel shame for this, they tend to resort to a specialist's help.

A finding that suggests a policy intervention is the relatively better position of young generations compared to their elders. Young women Roma independently of their gender are more educated. Although, age is not a significant factor for shame feelings, they do not have high levels of psychological distress as older Roma persons do,

thus they have better opportunities to change their future with adequate support from the society surrounding them. Positive role models and interventions in this direction should be addressed.

Education upgrades self-esteem and this well known fact was manifested as well in the present work. In recent past, Greek state made real efforts to provide adequate education to minorities and this policy were of benefit also for Roma people. Our study show that interventions are not in vain thus they should be continued as far as possible, while it is a big challenge to generalize and extent this interventions to older persons as well. Although, this should be the main state policy, a fact is that there are no legal or policy regulations to confront with discrimination of women from disadvantaged groups, thus further actions should be made in this direction as well, in particular that there is tremendous need for gender-responsive policies that address intersectional discrimination, such as that experienced by Romani women, especially in the area of education and employment.

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