CHAPTER-3

Cause and Consequence of Women's Mental Disorder: Perspectives on the Social-Epidemiological Connect

This chapter foregrounds the central argument of the study that social factors substantially influence mental health particularly that of women, because social structure at its rudiment is gendered and is disparagingly disposed towards the same. One of the paramount forces of division in society is gender, and a climacteric determinant of how resources are shared, status accorded and social space negotiated by male and female members of a society. It exercises profound influence on the social as well as psychological lives of people (Rosenfield and Smith, 2010). Gender differences significantly impact upon material well-being. World Health Report (WHO, 1998 cited in Astbury, 2001) makes a mention that social status and material well-being have a bearing upon health; therefore, women's relatively inferior socio-economic status makes them vulnerable to health issues including mental health issues. The fact that 70% of the world's poor are women (United Nations Development Report, 1995 cited in Astbury, 2001) endorses the fact that gender inequality manifests in material deprivation and socio-economic differentials which consequently presage a negative impact on women's mental health. Women's health activists resound the same idea that much of women's ill-health, including mental disorder, need to be attributed to the difficult social circumstances they find themselves enmeshed in (Davar, 1999). Dynamics of socialisation which vests men with authority, autonomy and agency and women with passivity and compliance; gendered division of the economic space in which the men hold sway over the productive sphere while the women are entrusted with the home and the hearth; discrimination at work place resulting in delegation of low-skilled jobs to women and lower remuneration packages in comparison to their male counterparts; burden of domestic work; striking a balance between work and home (particularly for working women) account for women's unique social experience and self-salience and have strong implications for their mental health. In a nutshell, women's (as well as men's) mental health is shaped by their experience and concept of selfhood conditioned by their social circumstances. However, women, having less control over the social determinants of mental health, are more vulnerable to mental disorders (Rosenfield and Smith, 2010). In the ensuing sections of the chapter the social

epidemiological connect in the context of women's mental health shall be explored. As iterated in chapter one, the scope of study includes common mental disorders among women and their social genesis. Socialised gender roles shape emotional expression of men and women, therefore, higher incidence of common mental disorders among women reflects that the same are conditioned to internalizing their emotions while the men to externalizing theirs. The consequence being that women are more susceptible to mental disorders such as depression, anxiety and phobia while men more commonly engage in substance abuse and anti-social behaviour (Busfield, 1996). Women's mental health is delved into hereafter from the sociological perspective.

3.1 Stress and Mental Health of Women

Many a commentator on women's mental health has recoursed to stress theory in explaining the connection between social factors and mental disorders. Conceived by Hans Selye (1950) (who expounded the manner in which prolonged exposure to stressful factors wears out the adaptive ability of the body which consequently results in health issues), this theory has served the interests of scholars, particularly the feminist scholars who sought to locate the cause of women's mental disorder in their social circumstances. Scholars have claimed that distress caused by life experiences of women portends psychiatric morbidity among the same. Bhargavi Davar (1999) vociferously claims that common mental disorders among women are caused by stressful factors that are archetypical markers of a woman's social life; accordingly, she asserts that women's mental health should be addressed from the perspective of distress rather than illness. She emphasizes on the sociality of distress experience which draws attention to the everyday encounters in a women's social life in addressing their mental health issues.

The positive relation between social stressors and mental distress has been endorsed by scholars of the domain, however, what is worthy of attention here is the vulnerability of certain groups more than others to stressors. While social stressors forebode negative consequences for all, members of certain social categories such as women have been found to be more susceptible to the same owing to the way they have been socialized,

their accessibility to resources, their curtailed agency and autonomy and overall status in society (Scheid and Brown, 2010). "Repeated studies showed that rates of mental disorder, measured by patient statistics or community surveys, were higher in the lower social classes (Hollingshed and Redlich, 1958; Srole et al., 1962; Dohrenwend and Dohrenwend, 1969 cited in Busfield, 1996) and the concept of stress was invoked to account for this association.…Stress, it was suggested, was greater for those towards the bottom of the social structure…" (Busfield, 1996, 190). Going by this rationale it has been averred that women, who are traditionally accorded low status and are subjected to discrimination, are exposed to more stressors. Another perspective to this trajectory of thought is the one that expounds the interconnection between stressors and mental disorder by referring to the response mechanism adopted by men and women towards the same. It has been mentioned once before that men externalize their emotions while women internalize theirs which accounts for the prevalence of common mental disorders among them. While the way men and women have been socialised determines how emotions are ventilated by them, another explanation for the same is offered by the assumption that " where achievements rank higher than ascribed statuses individuals tend to blame others for their problems and their feelings are turned outwards; where achievements do not match ascribed statuses then individuals are more likely to blame themselves…Extended to gender, this would suggest that women are more likely to turn feelings generated by stress and tension inwards and to blame themselves because on 'standard' measures their achievement are more limited" (Jackson, 1962 cited in Busfield, 1996, 195). Women, whose achievements are truncated owing to the limitations imposed on them by society, are inclined to blaming themselves for the problems of life - a tendency that is clearly a psychological marker for depression, an important mental health concern to reckon with.

The domain of stressful events that impact mental health is rather diverse. While some studies (especially epidemiological research) take into consideration the issues that feature in everyday lives of women such as divorce, unemployment etc. (Busfield, 1996), others focus on bigger and more consequential events in their lives (Lazarus and

Cohen, 1977 cited in Busfield, 1996). Also, what events portend stress has been debated by scholars. In this regard, the rationale that what is stressful is subjective to the individual concerned and therefore, evades standardised assessment holds water (Brown and Harris, 1978 cited in Busfield, 1996). Though stress theory is not without its limitations, nevertheless, it befits the scope of the present study and therefore is relied upon as a frame of argument.

Rogers and Pilgrim (2005) refer to Brown and Harris (1978) who in their study on social origin of depression classified certain factors that acquire the magnitude of stressors in the lives of women, making them more susceptible to mental disorders. Some such factors include:

- ✓ Vulnerability factors such as loss of mother before the age of 11, absence of a partner to confide in, unemployment, having three or more children which often result in depression.
- ✓ Provoking agents present in a women's life such as bereavement of a close one, breakdown of marriage, severe illness and other events encompassing chronic difficulties as well as major stressors which predicate the onset of depression
- ✓ Symptom-formation factors such as old age and recurrence of depression which determine the severity and form of depression.

Additionally it has been suggested that women with low self-esteem and those that live with a sense of humiliation and entrapment are particularly vulnerable to mental disorders such as depression. It may be worthwhile to recall, at this juncture, certain aspects of a woman's existence (apart from those that have been mentioned earlier) which makes them vulnerable to the stressors they are faced with in their lives. Absence of strong social support, strong emotional involvement with others and the burden of care heaped on women act as stressors and cast a negative influence on their mental health (Busfield, 1996).

Despite the fact that stress theory is not shorn of limitations in providing a substantial framework on what characteristics of the social environment cause stress,

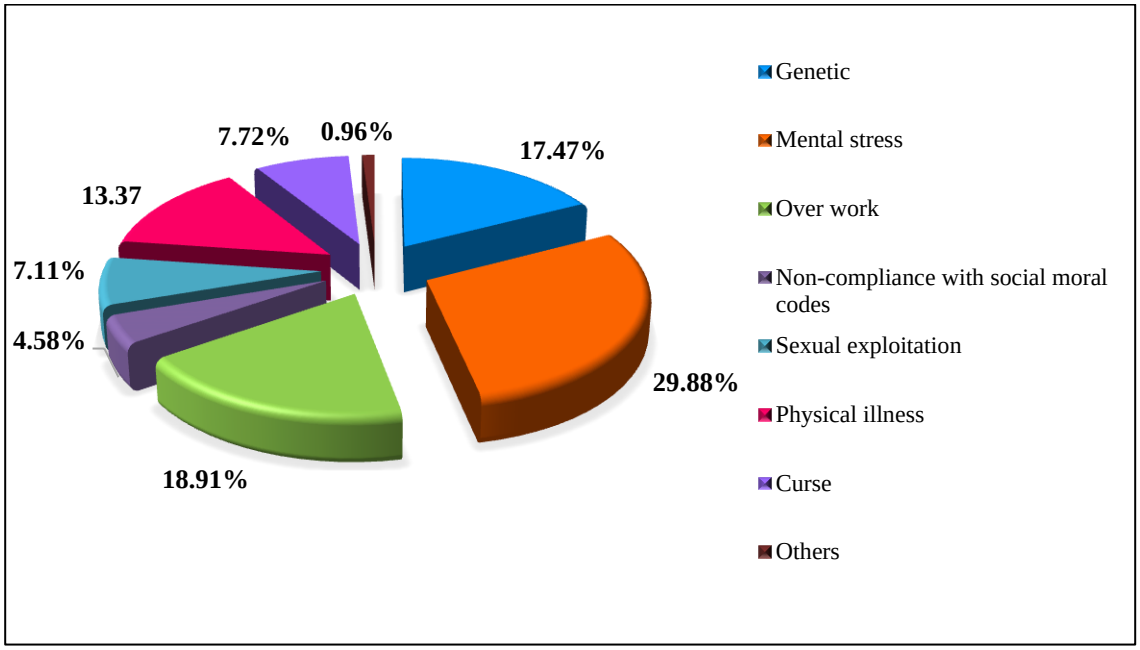
nevertheless, the same has courted much popularity for having established a veritable connection between aspects of one's social circumstance and mental health (Busfield,1988). This approach is especially conducive in studying the spectrum of common mental disorders that afflict women as the same, more often than not, have a social rather than a biogenetic genesis (Davar, 1999).

The data collected from the field by the present study testifies to the above argument. The opinions of the respondents were sought on the common causes of mental disorder among women. A range of optional answers (reference for the same had been drawn from the literature explored for the present study) were provided, out of which the respondents opted for stress as the most dominant cause. The suggestion made by researches of the domain as well the voice from the field are in consonance in suggesting that stress (followed by burden of work and genetic factors) poses the greatest threat to mental health of women. A whopping 29.88% of women indicated at stress as the major cause of mental disorders among women. The table and the corresponding chart provided below reflect the opinion of the respondents as recorded in the field.

Table 2: Causes of Mental Disorder in Women

Sl. No.	Causes of Mental Disorder	Frequency	Percentages
1	Genetic	145	17.47
2	Mental stress	248	29.88
3	Over work	157	18.91
4	Non-compliance with social moral codes	38	4.58
5	Sexual exploitation	59	7.11
6	Physical illness	111	13.37
7	Curse	64	7.72
8	Others	8	0.96
	Total	**830**	**100**

Figure 1: Causes of Mental Disorder in Women



3.2 Social Stressors and Mental Distress of Women

Having evinced that stress generated by social circumstances may negatively impact mental health, some social factors that act as stressors in the lives of women are being discussed here.

3.2.1 Marriage and Mental Health

One of the social factors that can be distressful for women is marriage. Marriage and child bearing constitute important aspects of women's social life and both are potential stressors for them, as many scholars have opined. The role of a woman as a wife is characterized by subservience to the husband and his kins and dedication to the children, the elderly and the ailing in the family – in a nutshell to be bound to the home and the hearth. In traditional social set-ups, the life of a woman is regulated by the husband and the in-laws, and the overall demands of the household which curbs their personal aspirations and delimits their agency. The roles and responsibilities that marriage entails have been observed to be particularly distressful for the women which,

as argued by many, can negatively impact their mental health (Davar, 1998; Adlakha, 2008). For long sociologists have reflected upon the merits of social relationships, including marriage, for strengthening social cohesion and forging emotional connect among members of a society (Umberson and Williams, 1999; Waite, 2009 cited in Williams et al., 2010). It was argued that marriage enhanced psychological well-being and functioned as an antidote to mental distress (Williams et al., 2010). Nevertheless, the cognizance that the relationship between marriage and mental health is not as unproblematic as projected and that macro–level social forces such as the social, economic and cultural context as well as the extent to which marital roles are personally congenial to the individual(s) concerned need to be factored in to make a comprehensive assessment of the impact of marriage on mental well-being propelled researchers to expand the scope of their exploration and delve into the nuances of the relationship between marriage and mental health (Simon, 2014).

The voice of dissent to the claim that marriage positively impacts mental health was sounded by many scholars, particularly the feminists. Charlotte Parkins Gilman (cited in Busfield, 1996), among some others, has leveled the blame for women's mental disorders on the oppressions they are subjected to and the burden of responsibilities they have to shoulder in their marital homes. Betty Friedan in her book, *The Feminine Mystique* (1963 cited in Busfield, 1996) has explained how the role of housewife can be onerous and frustrating for the women and may result either in divorce or mental disorders like depression and anxiety (Busfield, 1996). The argument proffered here is that marriage may not augur well for women. Walter R. Gove's (1972) exploration of the relation between marriage and mental illness is widely regarded as one of the most comprehensive accounts on the subject. Gove contests the claim that the unmarried and the never married are prone to mental disorders while the married enjoy good psychological health; rather, he asserts that it is the prevalence of mental disorders among married women which accounts for the high incidence of mental illness among women in general. Gove (1972) also negates the notion that women's mental disorders are to be attributed to their biological disposition and brings to light the roles married

women have to play and the impact of the same on their mental health. He makes a comparative analysis of the roles married men and women are obliged to perform, contending that the roles performed by the latter are relatively disparaging and therefore forebode a negative influence on their mental health. Firstly, he brings to fore the fact that women's structural base is tenuous as they play a single role, that of a housewife, while men play a dual role that of the household head as well as the primary breadwinner. This enables the man to shift attention from one role to other, should one or the other be unfulfilling for him. Secondly, the low-skilled and low prestige job of housewives frustrates the same owing to the little scope it allows for realization of their aspirations. Thirdly, the housewife's role is invisible leaving them with ample time to brood over their lot which may weigh on their minds. Fourthly, the employed married women often live with the dissatisfaction of workplace discrimination and the stress of balancing work and home responsibilities (as the burden of housework has to be shouldered by women even if they are employed). Finally, Gove emphasizes that the vague and diffuse expectations confronting women coupled with the uncertainties shrouding their future make their role particularly difficult. Thus, Gove clearly indicates at the marital roles as baleful to women's mental health. Gove substantiates his argument by referring to studies that have revealed that in the married category more women are reported as suffering from mental disorders. This is clearly indicative of how the role played by married women can be distressful for them.

In the Indian context, the institution of marriage presages greater complexities owing to the traditional structure in which it is embedded. Some of the malefic characteristics of the institution such as the dowry system, aspiration for male child and polygamy (in select communities) compound the distress resulting from this institution. The discrimination and oppressions that take place within the marital home result in higher rate of mental disorder among married Indian women. Davar (1999) is of the opinion that marriage is a stressful occupation for women and therefore, drawing from studies conducted on the subject, she points out that the rate of neuroses and common distress is highest among housewives. Marriage defines the roles and responsibilities to

be shouldered by women; the role women are expected to perform, however, is complex which demands the same to live up to conflicting expectations. In this context Sharma refers to the work of sociologist Susan Wadley who after "examining the identity of women in folklore, myths, and legends rooted in history, observed that the Indian woman is constantly made to adopt contradictory roles – the nurturing roles as daughters, mothers, wives, and as daughter-in-laws, and the stereotyped role of a weak and helpless woman" (2013, 244-45). This oscillation is definitely stressful and bears the potential to weigh on the minds of the women. Addlakha (2008) explains how the role women are expected to play is distinctly different from the cultural ideation (particularly in the Hindu society), therefore, the status of wife and mother is psychologically baleful rather than rewarding for the women. Any discussion on marriage and mental health cannot evade the issue of motherhood, which in traditional societies is the hallmark of womanhood. Procreation is integral to marriage and women who fail to live up to the same have to bear the social and psychological brunt of it (Addlakha, 2008). Further, familial pressure (particularly from the in-laws) to bear a male child is an additional stress on the women. This aspect of marriage is also correlated with mental distress among women.

Again drawing from Sharma et al. (2013) one gains insight into how within marriage, the traditional role of the female is limiting, restricting and even boring, which may lead to depression. Moreover, in "traditional Hindu families there exists a rigid code of conduct for women which prevents communication and expression of emotions, especially negative ones, because of which there is higher prevalence of internalizing disorders such as depression in women compared to men" (Sharma et al., 2013, 245). Further, the patriarchal structure ensures that women are disempowered, their agency thwarted and their social status compromised by making them dependent on their male counterparts. Sharma et al. point out at how the patriarchal structure functions "to ensure complete dependence (of the females) on the male sex. Consequently, the constant movement from strength to passivity leads to enormous stress placing the woman's mental health under constant threat" (2013, 245). This fact is

more pertinent in the case of married women whose transition from their natal to their marital homes, in most cases, plagues them with multiple stressful circumstances, some of which are explored below.

The discriminations and oppressions that married women face have been decried by scholars for the effect they have on their mental health. With the view to studying the stressors that women are confronted with in their marital homes (as compared to their natal homes) the study interviewed 52 married women (within the stipulated sample) who suffer from some or the other kind of mental disorder to take their opinion on the aspects of married life that could be the cause of much of the rancour women experience and result in their mental distress. The study revealed that married women are subjected to discrimination and repressions which are indicated by the freedom they are entitled to, the decision making power they enjoy and the love and respect they receive in their marital homes. Further, the study also revealed that the burden of work heaped on the women, a significant stressor, is much more in their marital homes than in their natal homes.

The tables and figures provided below reflect that in all the aspects probed, women communicated the relative disadvantage they suffered in marital homes in comparison to their natal homes. As represented in Table 3 and in the Figures (2 a - d) provided subsequently, 48% of women complained of curtailment of freedom at marital home while 28.8 % women complained of restricted freedom in natal home. Further, 73% of women claimed to have enjoyed positive emotions like love, respect and care in their natal homes as against 51.9% of women who professed to have experienced these positive emotions in their marital homes. As regards decision making, 32.7% women claimed to have enjoyed the privilege in marital homes while 61.5% women have enjoyed the same in their natal homes. Lastly, 67% women were saddled with burden of work in their marital homes as against 30.8% women in their natal homes. It therefore becomes apparent that lives of married women are beset with several stressors which

redound to their disadvantage and adds to their consternation, thus dealing a blow on their mental health.

Table 3: Experiences of Married Women in Natal v/s Marital Home

		Natal House: Freedom		Total
		Yes (n= %)	No (n= %)	
Marital Home: Freedom	Yes	18 (34.61%)	9 (17.30%)	27 (51.92%)
	No	19 (36.54%)	6 (11.53%)	25 (48 %)
Total		37 (71.15%)	15 (28.84%)	52 (100%)
		Natal House: Respect/ Love/ Care		Total
		Yes	No	
Marital Home: Respect/ Love/ Care	Yes	21 (40.38%)	6 (11.53%)	27 (51.92%)
	No	17 (32.69%)	8 (15.38%)	25 (48.08%)
Total		38 (73.07%)	14 (26.92%)	52 (100%)
		Natal House: Decision Making Power		Total
		Yes	No	
Marital Home: Decision Making Power	Yes	8 (15.38%)	9 (17.30%)	17 (32.69%)
	No	24 (46.15%)	11 (21.15%)	35 (67.31%)
Total		32 (61.53%)	20 (38.46%)	52 (100%)
		Natal House: Burden of Domestic Work		Total
		Yes	No	
Marital Home: Burden of domestic work	Yes	11 (21.15%)	24 (46.15%)	35 (67.31%)
	No	5 (9.61%)	12 (23.08%)	17 (32.69%)
Total		16 (30.77%)	36 (69.23%)	52 (100%)

Figure 2a: Experiences of Married Women in Natal v/s Marital Home (Freedom)

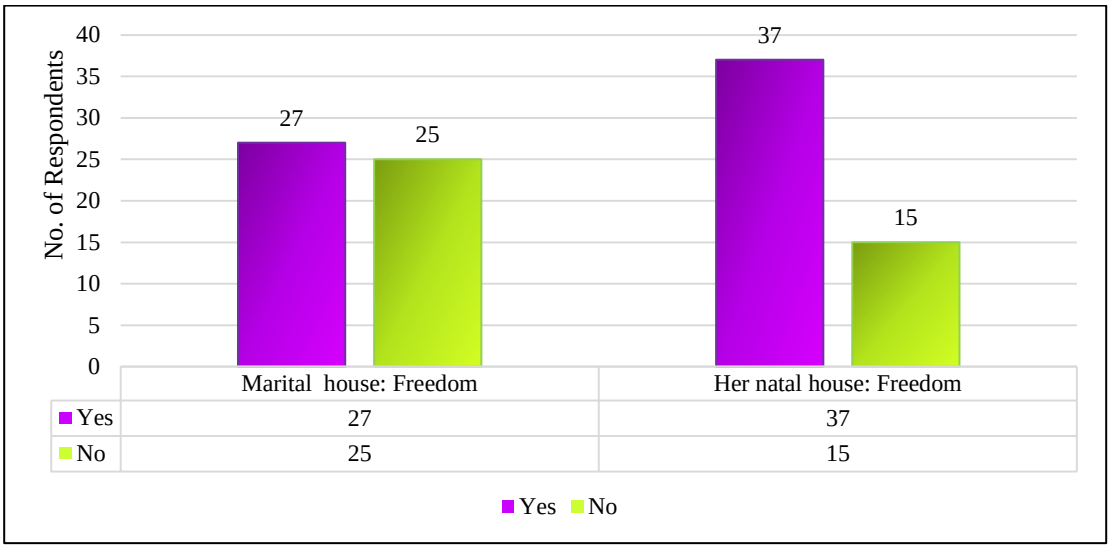


Figure 2b: Experiences of Married Women in Natal v/s Marital Home (Respect/Love/Care)

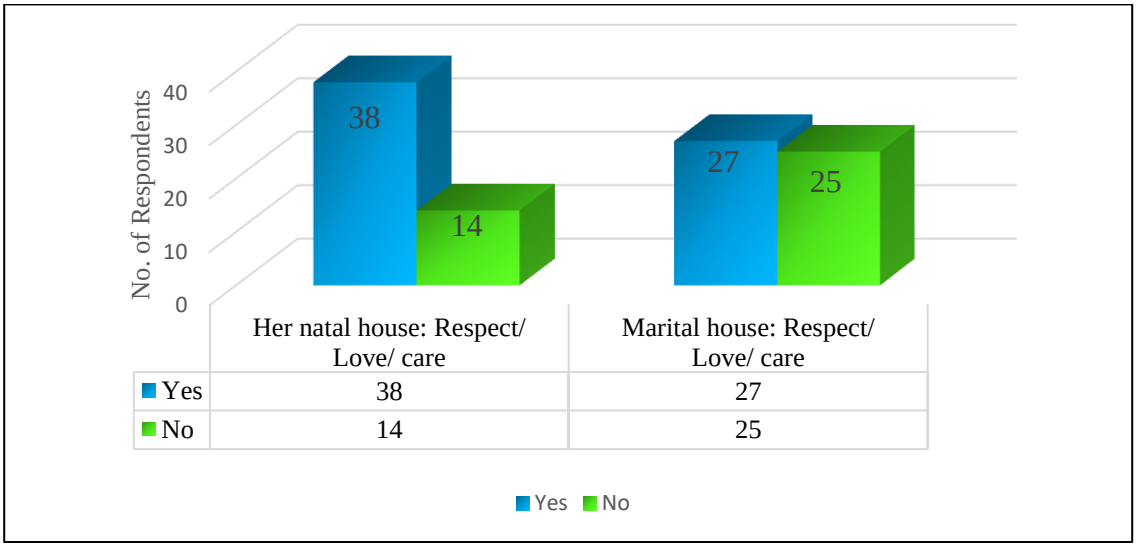


Figure 2c: Experiences of Married Women in Natal v/s Marital Home (Decision Making Power)

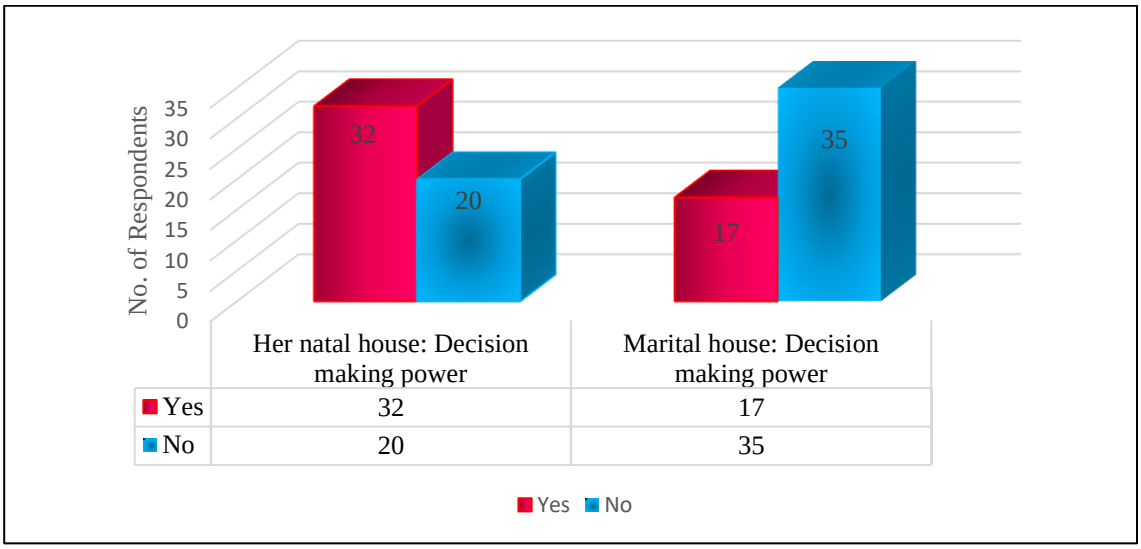
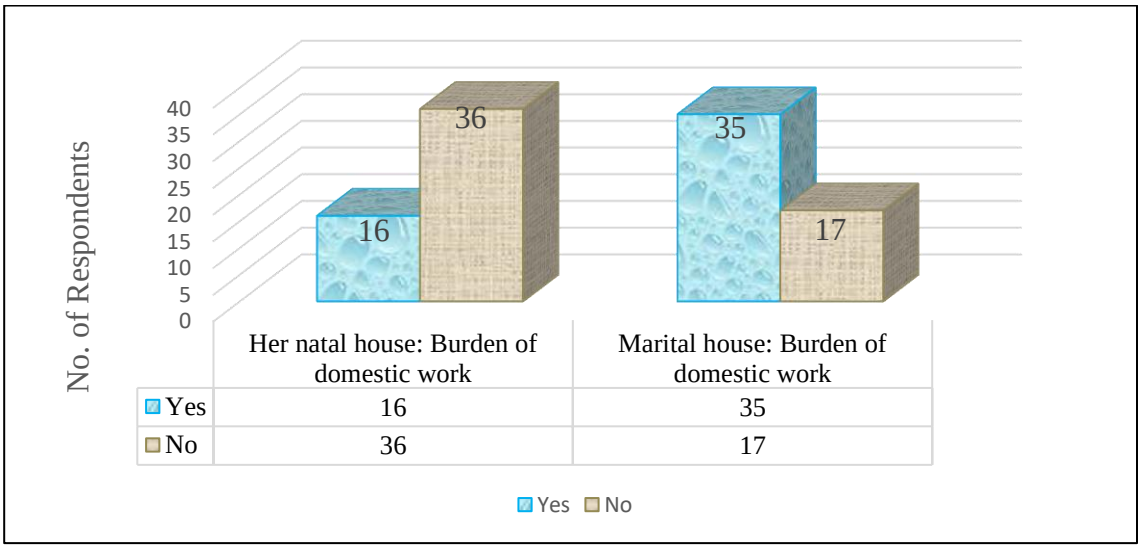


Figure 2d: Experiences of Married Women in Natal v/s Marital Home (Burden of Domestic Work)



Another important aspect of marriage that bears a direct relevance to mental health of women is that of domestic violence. Violence within marriage is a pretty common phenomenon that mars the life of many married women and makes them vulnerable to mental distress. The practices, customs, beliefs and myths fostered by the patriarchal structure of societies result in violence against women. Most often violence is related to dowry (a characteristic feature of Indian society), which has heaped untold suffering on women and in several cases has led not just to mental derangement but also to death. While effects of violence on mental health is only being alluded to her, chapter four shall deal with the subject in all its depth and profundity.

Sharma points out to a study on domestic violence undertaken by the International Centre for Research on Women (ICRW) in multiple centres in India, which "reported that 85 percent of men admit that they had indulged in violent behaviour against their wives; physical, emotional or sexual, at least once in the last 12 months. 57 percent of men admitted to have committed sexual abuse with their wives. 32 percent of men admitted to committing violence on their pregnant wives" (2013, 247) The resultant effect of domestic violence, as explained by Sharma (2013) may vary in nature, while many chose to suffer in silence few other react aggressively. "The psychological burden of the same emerges either as sub-syndromal or diagnosable disorders" (Sharma et al. 2013, 247).

Thus it becomes clear that marriage, the responsibilities it heaps on married women and the practices it endorses all contribute to high rate of mental disorder among them. Marriage has been associated with prevalence of depression among women than among men. Sharma (2013) points out at an ICMR and DST study on severe mental distress which indicates that the ever married (i.e. the married, the divorced/separated and the widowed) suffer more distress than those who were never married. Marriage, it is argued here, is one of the social stressors that play a decisive role in shaping women's mental health.

3.2.2 Economic Deprivation and Mental Health

High incidence of mental disorder has been observed among those belonging to the lower social classes (Neugebauer, Dohrenwend and Dohrenwend, 1980 cited in Perry, 1996). This relation between mental disorder and economic class was first established in the 1930s under the aegis of mental hygiene studies and has stood the test of time, so much so that even in the present times this relation remains undisputed. Several studies on the subject have, with reasonable conviction, explained this connection. Notably that of Faris and Dunham's (1939 cited in Perry, 1996) study conducted in Chicago which expounded on the prevalence of schizophrenia and psychoses among those living in the periphery of the society. Hollinshed and Redlich's (1950 cited in Perry, 1996) study conducted in New Haven, Conecticut and that of Dunham (1959 cited in Perry, 1996) in Detroit harp on the same chord. Economically disadvantaged individuals and groups are faced with sundry stressors in their everyday life which is compounded by the lack of social support that makes life particularly difficult for them. The disadvantaged section fails to mobilize resources and social support in their favour, because of which the stressors of their lives, more often than not, spiral out of their control. Such a state of existence causes collateral damage to the individual's/group's public as well as personal life and therefore it is hardly surprising that mental disorder abounds in the lower strata of society (Perry, 1996).

Bhargavi Davar (1999) rubs in the fact that economic condition prevails upon mental health owing to which women, who enjoy poor socio economic status, are more vulnerable to metal disorders. Referring to Neugebauer, Dohrenwend, and Dohrenwend (1980), Perry (1996) points out that the high incidence of common mental disorders such as anxiety and depression among women is linked to their economic status. It may be worthwhile to recall the statement released by UNDP (1998) that women constitute 70% of the world's poor, which is a categorical pronouncement on women's socio-economic status. Women's inaccessibility to education, economic resources, low representation in workforce and wage differential between male and female workers

place women in an economically disadvantageous position and exposes them to myriad vulnerabilities of life which, as the argument goes, negatively acts upon their mental health. Economic disadvantage has a profound impact on women's health. The brunt of poverty is disproportionately borne by the women. Health impact of an economically disadvantaged state is reflected in women's nutritional deficiencies, lack of health care and higher prevalence of morbidity (including mental morbidities) among them. One of the indicators of women's socio-economic status is their engagement in gainful employment; however, the present study has revealed that the percentage of employed women is far less in comparison to the men. Within a sample size of 830 households, it was found that only 293 women were employed which is a clear indication of the economically disadvantaged position of women in society.

In *Bridging the Gaps*, World Health Organization (1995) states that poverty is the world's most ruthless killer and the greatest cause of suffering on earth (cited in Murali and Oyebode, 2004). Murali and Oyebode explain that,

> …this statement emphasizes the importance of poverty as a variable adversely influencing health. Poverty is a multi-dimensional phenomenon, encompassing inability to satisfy basic needs, lack of control over resources, lack of education and poor health. Poverty can be intrinsically alienating and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioural and psychiatric problems. (2004, 216)

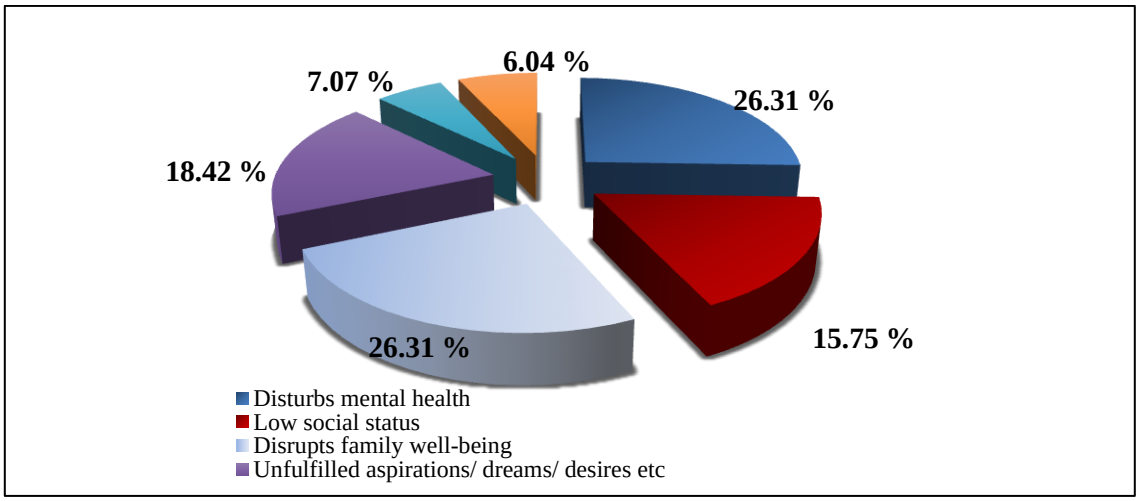
Poverty, as has been explicated above, has an adverse implication for mental health as the same has the potential to increase distress and frustration in life. This claim has been resounded by the women respondents (114 married and unmarried women within the defined sample size suffering from some or the other form of mental disorder) interviewed in the course of the study. Out of the responding women, 26.3% opined that poverty is inevitably correlated with the adverse effect it has on mental health. The

responding women have also reflected upon the unpropitious impact of poverty on family's well-being (26.3%); on life-aspirations (18.4%) and on social status (15.8%) as illustrated in Table 4/Figure 3 provided below. The disgruntle, arising out of the above factors, would inevitably bear upon the mental health of individuals, particularly women who by virtue of their position in society are more exposed to sqalour and penury.

Table 4: Opinion of Women towards Poverty and its Consequences

SI NO.	Impact of Poverty	Frequency	Percent
1.	Disturbs mental health	30	26.31
2.	Low social status	18	15.75
3.	Disrupts family well-being	30	26.31
4.	Unfulfilled aspirations/ dreams/ desires etc.	21	18.42
5.	Exposure to social threats and other risks	8	7.07
6.	Others	7	6.14
	Total	**114**	**100.0**

Figure 3: Opinion of Women towards Poverty and its Consequences



There exists a canon of sociological literature on the connection between economic deprivation and poor mental health. Many a scholar has dwelt upon the stressors associated with an economically deprived status and how the same may have an unfavourable impact upon one's mental health. Poverty, low level of education, financial insecurity and lack of control over resources of sustenance that typically characterize lives of the economically deprived have been considered as correlates of mental disorders. Murali and Oyebode explain that "one reason for this phenomenon may be that relative deprivation is a catalyst for a range of negative emotional and cognitive responses to inequality. That is, levels of inequality have a strong impact on how people feel and how people feel (emotional wellbeing) is a powerful indicator of their mental health" (2004, 217). Low socio-economic status poses as a deterrent in accessing resources and opportunities of life thereby leaving its imprint on the experience one encounters at personal and professional levels. The accumulated distress resulting from thwarted opportunities and unfulfilled aspirations of life brought, about by economic deprivation, is underscored here as one of the definite threats to mental health.

Economic deprivation contributes to negative life experiences which prevail upon one's physical and mental health. The study has made an attempt to study the veracity of the above supposition, by inquiring into those aspects of life that are most affected by economic status. The subject has been explored with women respondents (114 married and unmarried women within the defined sample size suffering from some or the other form of mental disorder) who voiced their opinion in favour of the argument that economic deprivation does compound the woes of life and contributes to mental distress. Table 5/ Figure 4 (a-b) provided below represents that a majority of the women (61.4%) acknowledged the importance of money in their lives, a paucity of which resulted in negative life experiences such as poor health (33%); incomplete education (25%) and early marriage (24.5%). It is argued here that negative life experiences, brought about by economic deprivation act as stressors which in due course impinge on mental health of those who have to live through such experiences.

Table 5: Value of Money and Impact of Economic Deprivation on Life Opportunities

		Impact of economic deprivation on life opportunities						Total (out of 830 respondents) (N= %)
		Incomplete/ no education	Early marriage	Strenuous jobs	Health issues	Social discrimination/ exploitation	Others	
How important is money in life?	Very important	18	18	2	22	9	1	70 (61.40%)
	Not very important	5	8	0	5	3	1	22 (19.30%)
	Not important at all	6	2	1	11	1	1	22 (19.30%)
Total		29 (25.4 %)	28 (24.5%)	3 (2.6%)	38 (33.3%)	13 (11.4%)	3 (2.6%)	114 (100%)

Figure 4 a: Value of Money and Impact of Economic Deprivation on Life Opportunities

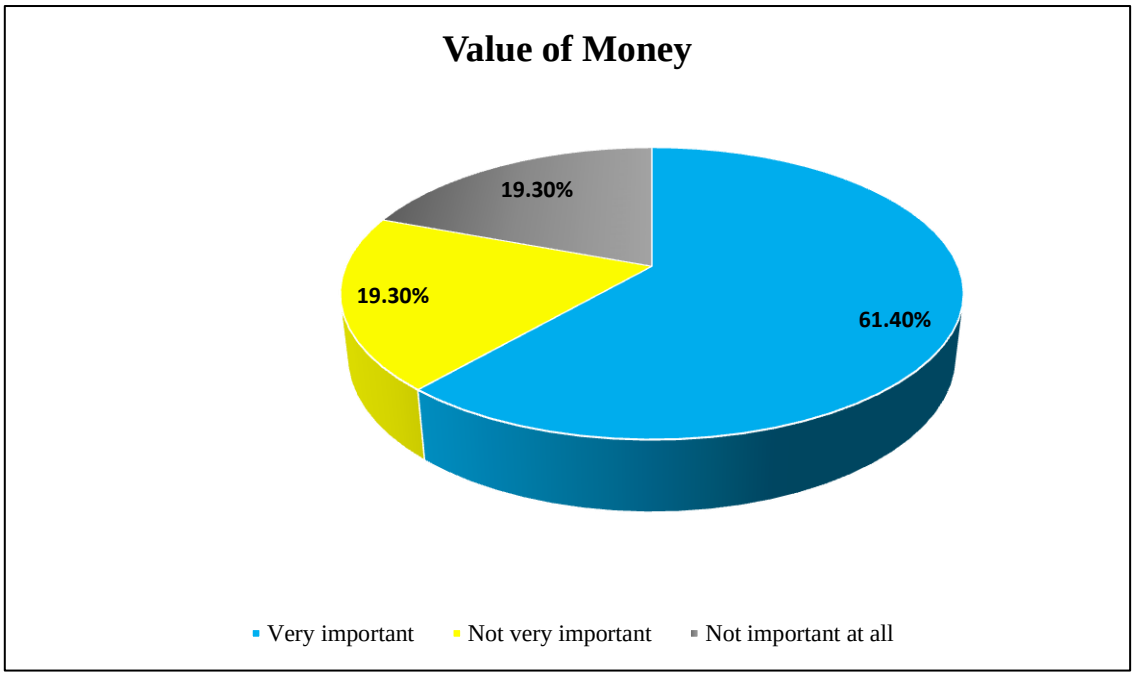
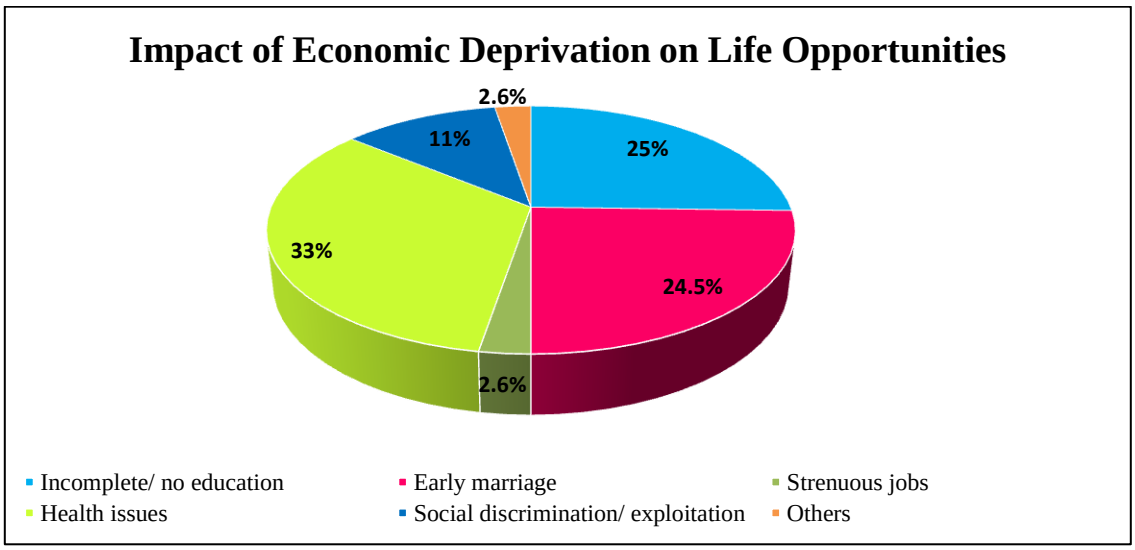


Figure 4 b: Value of Money and Impact of Economic Deprivation on Life Opportunities



Women's low economic status exposes them to several forms of stress, particularly women with no or minimal social support (e.g. single mothers) who are likely to be exposed to chronic economic stressors which in turn may wear out their psychological coping abilities and culminate in morbidities like depression (Belle, 1990 cited in Perry, 1996). With the view to gauging the travails of single women, 106 households (within the stipulated sample of 830 respondents) headed by women (who were either widowed or abandoned by their partners) were included in the study. Majority of the women interviewed in this category , as revealed by the data, complained of feeling burdened (43.4%) and insecure (29.3 %) and being saddled by economic crisis (70.8%) as lone breadwinners of their families. The chronic stressors that these women experience in their everyday lives, as argued by scholars, presage psychological morbidities. Table 6/Figure 5 a & b provided hereunder are figurative depictions of the argument presented above.

Table 6: Experience and Difficulties of Women Headed Households

		Difficulties of Women Headed Households				**Total**
		Economic crisis	Social discrimination	Security issues	Any other	
How do you feel about you being the head of the household?	**Empowered**	14	2	0	5	21 (19.81%)
	Insecure	24	0	7	0	31 (29.25%)
	Burdened	32	6	7	1	46 (43.39%)
	Others	5	0	2	1	8 (7.55%)
Total		**75 (70.75%)**	**8 (7.55%)**	**16 (15.09%)**	**7 (6.60%)**	**106 (100%)**

Figure 5a: Experience and Difficulties of Women Headed Households

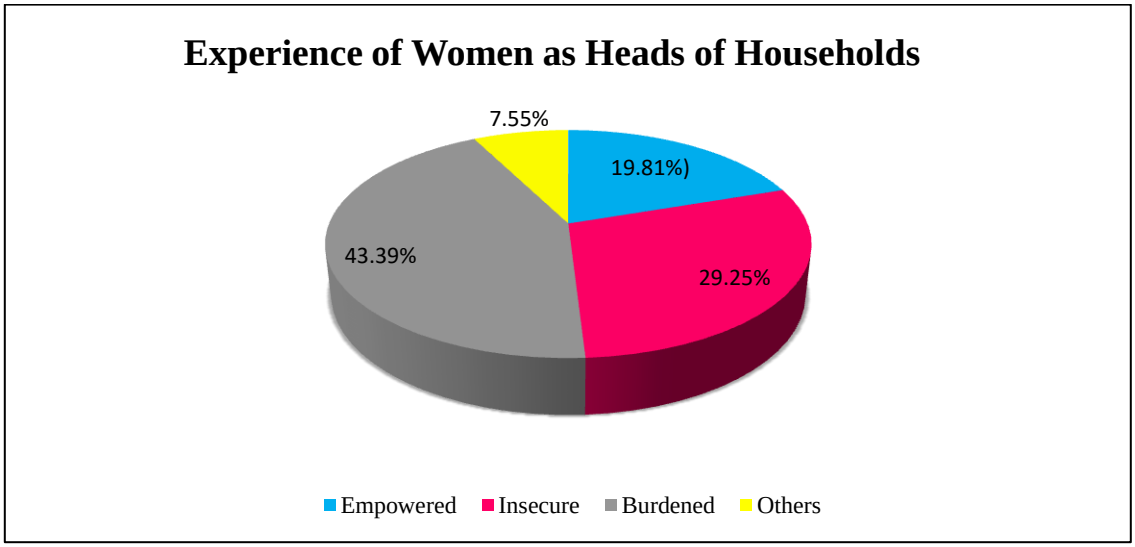
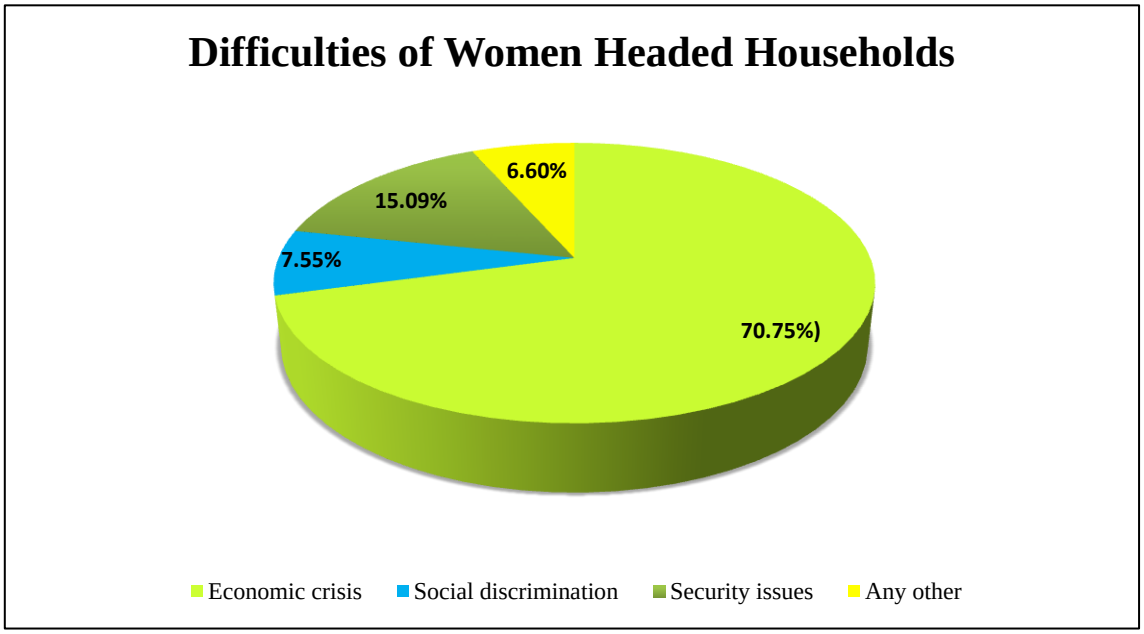


Figure 5b: Experience and Difficulties of Women Headed Households



Further, to substantiate the influence of economic and associated structural factors on the distribution of health, we may draw from the materialistic theories which implicate economic deprivation and the adversities associated with the same for the prevalence of physical and mental illness among those that are mired in such disadvantageous circumstances (Murali and Oyebode, 2004). Stressors experienced by the poor women, it is argued here, is much more as they are confronted with distressful events at home and are, more often than not, exposed to hazardous work life (owing to low level of education and skills which capacitates them to participate in laborious and physically demanding work). The economically disadvantaged women experience much greater distress in managing work and life, therefore are way more vulnerable to the threat the same poses to their mental health. As Murali and Oyebode put it, "people in lower socio-economic classes by virtue of their life circumstances are exposed to more stressors, and with fewer resources to manage them and greater vulnerability to stressors, they are doubly victimised" (2004, 217).

In this context, the present study ventures to explore the everyday life events that economically disadvantaged women were exposed to particularly in managing their households. The onus of domestic affairs largely rest on the women and much of their distress stems from the same. The respondents were classified under different income range and it was found that in lower income groups, women experienced difficulties in managing food for consumption of family members, managing health related expenses, and education related expenses of children as Table 7 provided below reflects. The drudgery of everyday life, as is argued here, is distressful for the women on whom the responsibility of domestic affairs generally devolves and who are held responsible for any mismanagement in this demesne.

Table 7: Total Monthly Income and Difficulties Women Experience in Running Household

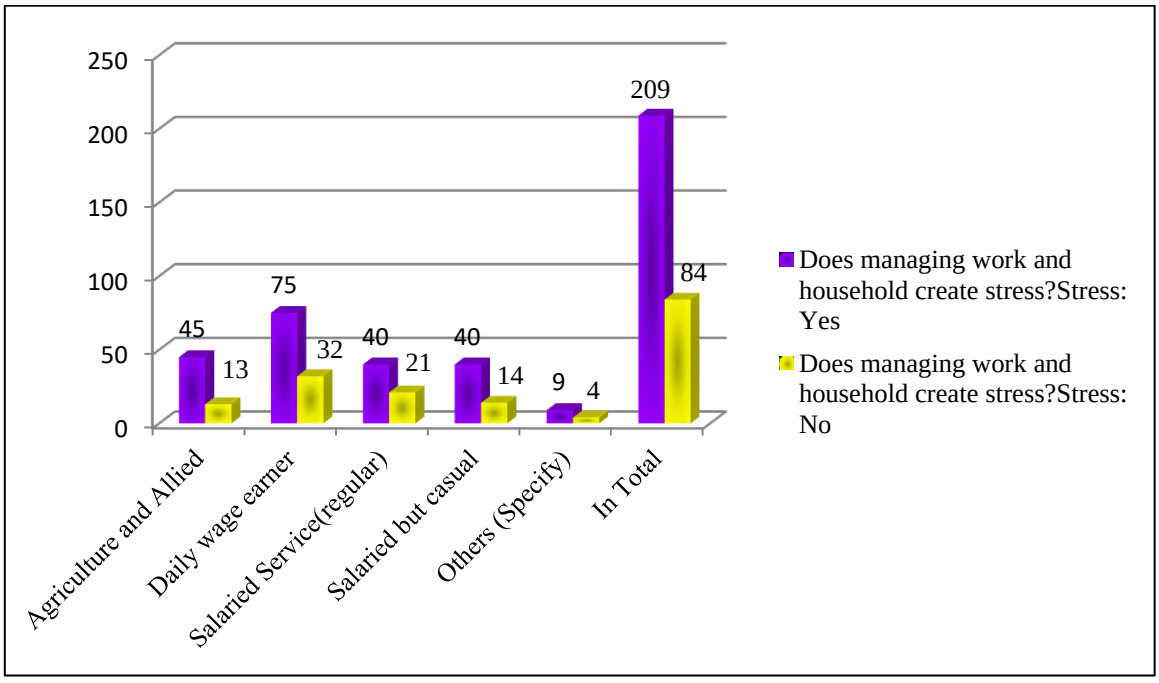
		Difficulties Women Experiences while Running the Household within the Limited Monthly Income				Total
		Difficulty in providing at least two square meals for the family.	Difficulty in providing education for the children.	Difficulty in covering health related expenses.	All of the above	
Total income (per month) of the house hold	Up to 1000	23	3	9	9	44
	Between 1001 to 5000	41	35	64	219	359
	Between 5001 to 9000	21	33	55	154	263
	Between 9001 to 13000	7	5	35	54	101
	Between 13001 to 25000	3	4	35	9	51
	Above 25000	1	1	10	0	12
Total						**830**

There are several obstacles, deficits and threats to health inherent in poverty. It is the poor who are exposed to hostile environment, who have to live without basic amenities of life, who lack social support and who are employed in stressful, unrewarding and depersonalising work (Murali and Oyebode, 2004). Economically deprived, women often have to take up jobs to support their family. However, a relevant issue that merits mention in this context is the distress that is caused by work-life conflict in the lives of working women. Striking a balance between life and work is a stressful enterprise for women of all socio-economic categories; more so for the economically deprived women who have to juggle with adversities at the domestic front with the demands of work place. This concern was taken up with the respondents (293 working women out of the 830 women interviewed) and it was found that 71% women of different occupational categories experienced mental distress in balancing work and home as is mirrored in Table 8/Figure 6 provided below.

Table 8: Nature of Work and Stress Experienced by Working Women

		Nature of work.					Total
		Agriculture and Allied	Daily wage earner	Salaried Service (regular)	Salaried but casual	Others (Specify)	(out of 830 respondents)
Managing work and household : stress	Yes	45	75	40	40	9	209 (71.33%)
	No	13	32	21	14	4	84 (28.67%)
Total		58	107	61	54	13	293 (100%)

Figure 6: Nature of Work and Stress Experienced by Working Women



Kumar (2005), in exploring the poor mental health of the economically disadvantaged women delves into the hostilities that women of the low socio-economic strata are confronted with in their everyday lives. Domestic violence is one of the prominent hostile forces that feature in the lives of women. Kumar states that economically disadvantaged women are already

> ….faced with enormous social, physical and economic stresses, which in association with the experience of domestic violence are likely to increase their vulnerability to mental morbidities (Patel et al., 1999 cited in Kumar et al.,2005). Heise (1998 cited in Kumar et al., 2005) postulated that poverty probably acts as a marker for a variety of social conditions that combine to increase the risk of violence faced by women. (2005, 65)

Thus, as has been iterated above, poverty is more striking in the lives of the women than that of the men. Women form a social class of their own; a class that is beset with its social and economic disadvantages and as explained, low socio-economic status is a determinant of poor mental health. Through empirical data presented in this section, it has been established that economic deprivation exposes women to an array of stressors which have the potential to disturb mental health. The argument that low socio-economic status adversely affects mental health is more pertinent in the case of women owing to the disadvantages associated with their position in society.

3.2.3 Religion and Mental Health

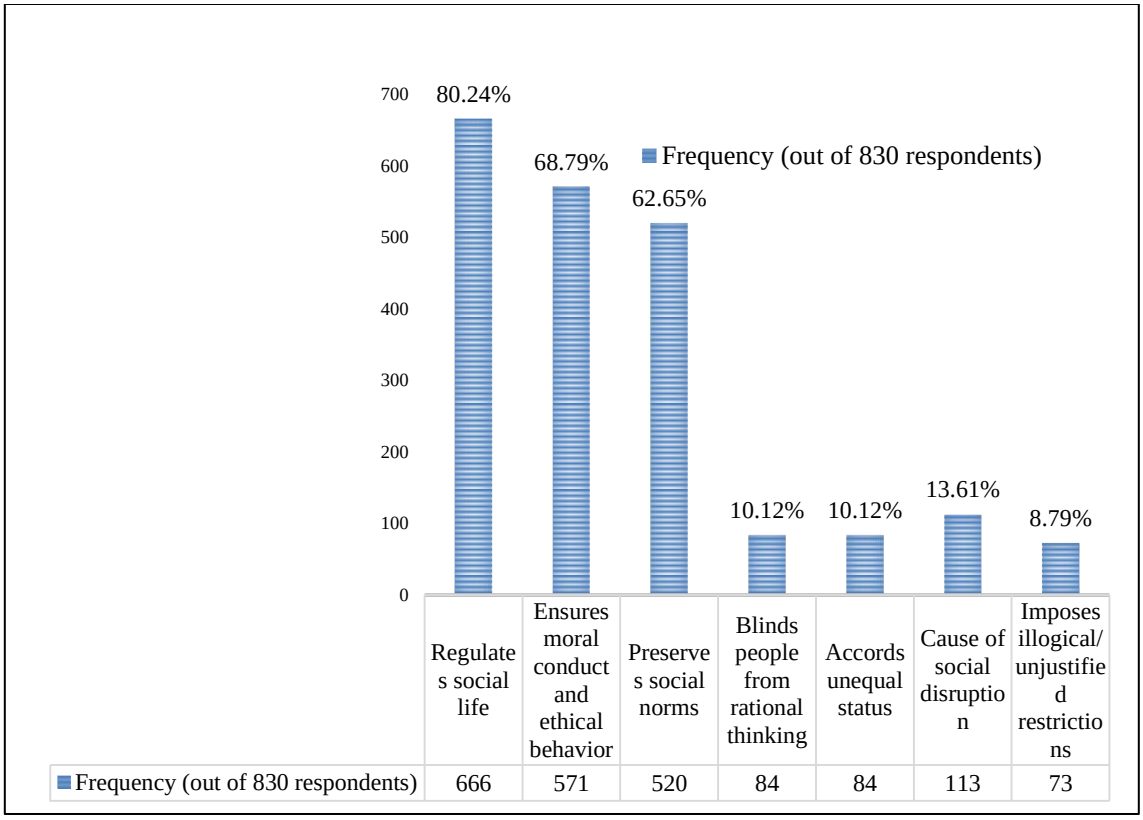
Yet another stressor in the lives of women is religion, which is one of the institutions of society that regulates social life. The role, responsibility, status and power wielded by different social groups (whether arranged in terms of caste or gender) are sanctioned by religion. Adherence to such strictures is assured through ratified norms and sanctions on attempts at transgression of the same. Margaret Andersen (1997) puts forward her view that religion exercises control over the manner in which

personal and communal identities are formed by accrediting certain socio-cultural practices and denouncing some others that threaten the traditional structure of power. "In the extreme, groups who deviate from religious proscriptions may be tortured, executed, or excommunicated; in more subtle ways, religious deviants may be ridiculed, shunned or ostracized" (Andersen, 1997, 226). Religion claims to provide authentic and divinely sanctioned standards of thought, conduct and communal living and acts as a regulatory mechanism. Okon suggests that "religion arrogates to itself the duty of a 'watchdog' and social umpire. As the acknowledged custodian of human ideals and aspirations, religion has always provided a platform for social control" (2012, 141). The fact that religion plays a regulatory role in society has been ascertained by the data collected from the field. Majority of the respondents (80%) have voiced their opinion in favour of the same. Further, the role played by religion in conserving the codes of morality and social norms is also amply supported by views (68.8% and 62.7 % respectively) obtained from the field. Table 9/ Figure 7 provided here is representative of the claim made above.

Table 9: Impact of Religion on People's Lives

Sl. No.	Reason (as many as)	Frequency (out of 830 respondents)	Percentage
1.	Regulates social life	666	80.24
2.	Ensures moral conduct and ethical behavior	571	68.79
3.	Preserves social norms	520	62.65
4.	Blinds people from rational thinking	84	10.12
5.	Accords unequal status	84	10.12
6.	Cause of social disruption	113	13.61
7.	Imposes illogical/ unjustified restrictions	73	8.79

Figure 7: Impact of Religion on People's Lives



	Regulates social life	Ensures moral conduct and ethical behavior	Preserves social norms	Blinds people from rational thinking	Accords unequal status	Cause of social disruption	Imposes illogical/ unjustified restrictions
Frequency (out of 830 respondents)	666	571	520	84	84	113	73

Gender Inequality is one of the most pervasive forms of inequality that characterizes all societies across the globe. A patriarchal society is endowed with several instruments of control which are employed to regulate social hierarchies with the intent to restrain the weaker sections of the society (including women) in their confines of powerlessness and enable the dominant forces to retain their monopoly over social power and resources. Religion is one such instrument of control which plays a significant role in determining the status of women in a particular society. One of the early thinkers to have drawn attention towards the concept of religion as a tool of social control is German philosopher Karl Marx who termed religion as the opium of the masses, in other words religion clouds the perception of people with false ideology which prevents them from perceiving the reality (Marx, 1844). Marx had categorically pronounced how

religion lends itself as a tool in the hands of the socially powerful to keep the disempowered in their present situation. Being favourably disposed towards the empowered class, religion according to Marx , legitimizes the former's power, authority and control over the hapless groups. Such a control mechanism, which because it gains the favour of religion becomes more coercive and compelling. As expounded by Marx, religion performs an ideological function related to the idea of reification. Reification wraps in its injunctions ideas that in reality are arbitrary and changeable and posits them as inviolable, immutable and inconvertible. Thus, reification of socio-cultural practices is a more viable form of social control as it generates ideas which reins each group of society within its designated ambit and sustains the traditional structure of power and control. As Marx reflected, religion is an ideological instrument, and the dictum it formulates is largely influenced by dominant powers to ensure the tilt of power in their favour. By regulating women's sexuality, by imposing censures on them on the basis of their supposed purity and pollution, by hindering their active involvement in the public sphere and by delimiting their role in religious rituals, religious doctrines, ideologies and practices, largely monopolized by the men, work in tandem to accord women a lesser status and to regulate their lives in accordance with the machinated norms.

Though the influence of religion is variable across space, yet the fact that it substantially impacts upon women's lives and their social status remains invariable. Lay observation as well as academic research has revealed that world religions reflect patriarchal values (Nespor, 2008 cited in Klingorova and Havlicek, 2015), endorse male dominance (Young, 1987 cited in Klingorova and Havlicek, 2015) and accord an inferior status to women (Holm, 1994; Krejčí, 2009 cited in Klingorova and Havlicek, 2015). Though religions apparently advocate in favour of respect for women, they stop short of offering equal status to men and women.

> Male and female roles are therefore much differentiated and also unbalanced in the world religions. The influence of women on the formation of religious norms and traditions is small, even though in

> certain doctrines, we can find women who succeeded in having their normative views accepted, or men who advocated equal integration of women into religious ceremonies. It needs to be stated that there exists a certain discrepancy between normative conditionality, which refers to what the given religion proclaims (equality of men and women before God) and practical conditionality, which involves the role of women in religious communities and state societies in terms of everyday life. (Holm, 1994 cited in Klingorova and Havlicek, 2015, 3)

Therefore, it is well understood that religion is one of the most cogent institutions that rationalizes and enforces inferior status of women in relation to their male counterparts. The space that women are able to negotiate in religious activities is an indicator of the status and value they are accorded by religion. Therefore to probe the veracity of the argument made above, the opinion of women were sought on the restrictions and regulations imposed on their participation in different aspects of religious life. The responding women (most of whom follow Hinduism or Islam), as revealed by the data, did experience some restriction in all aspects as the Table 10/Figure 8 below reveals, with the greatest restrictions experienced in the performance of funeral rights, followed by those experienced by widowed women with restrictions on attending prayers (particularly during menstruation, pregnancy and other supposedly polluted phases of a woman's life) trailing behind. Though the data from the field indicates the norms prevalent among the Hindus and the Muslims, the same is, nevertheless, indicative of the situation that prevails among followers of other major religions like Christianity and Buddhism.

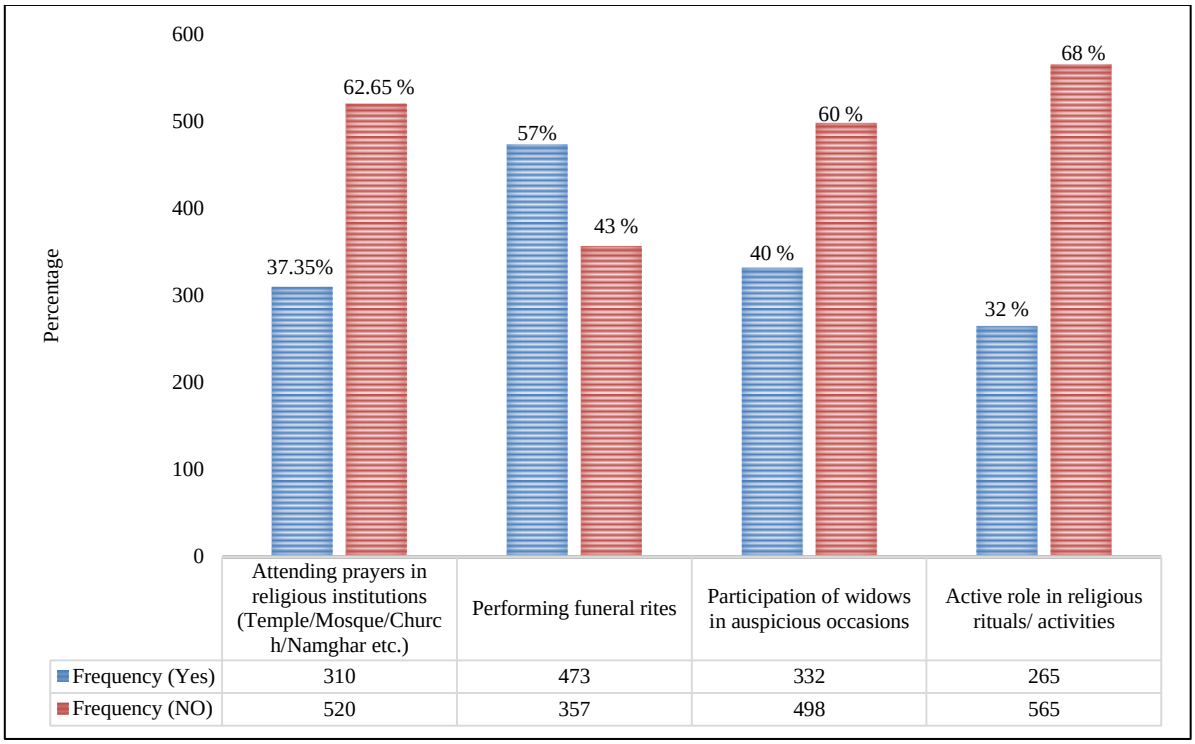
Though a good number of women (43%-68%) denied facing much restriction in religious participation, the number of women who acknowledged the restrictions faced by them is considerable (32%-57%). While there is no denying the fact that women do face restrictions in various aspects of religious life; the same is so naturalized in many women owing to the manner in which they have been socialized, that they fail to

acknowledge the reality as it stands. In this context, Marx's reference to religion as generating false consciousness may be recalled, where he made it amply clear that religion legitimizes the suppression of the weak in a manner that the same is naturalized by the latter. Therefore, the oppressed fail to cognize the manner in which they have been oppressed, rather accept the same as a natural state of affairs. This accounts for greater number of women claiming that they face no restrictions in religious participation. Nevertheless, the fact remains that women do face restriction and resistance in uninhibited participation in different aspects of religious life. It is pointed up here that the restrictions imposed on women imply that they are not considered worthy of participation in rituals of higher order owing to their supposed weak moral and spiritual fiber and their relative inferiority in comparison to their male counterparts. Thwarted participation of women in religious rituals is interpreted here in terms of the low social status that religion accords to women.

Table 10: Restrictions on Women's Participation in Religious Life

SI. No.	Restrictions	Frequency (Yes)	Percentage %	Frequency (No)	Percentage %	Total
1.	Attending prayers in religious institutions (Temple/Mosque/Chur--ch/Namghar etc.)	310	37.35	520	62.65	830 (100%)
2.	Performing funeral rites	473	57	357	43	830 (100%)
3.	Participation of widows in auspicious occasions	332	40	498	60	830 (100%)
4.	Active role in religious rituals/ activities	265	32	565	68	830 (100%)

Figure 8: Restrictions on Women's Participation in Religious Life



	Attending prayers in religious institutions (Temple/Mosque/Church/Namghar etc.)	Performing funeral rites	Participation of widows in auspicious occasions	Active role in religious rituals/ activities
Frequency (Yes)	310	473	332	265
Frequency (NO)	520	357	498	565

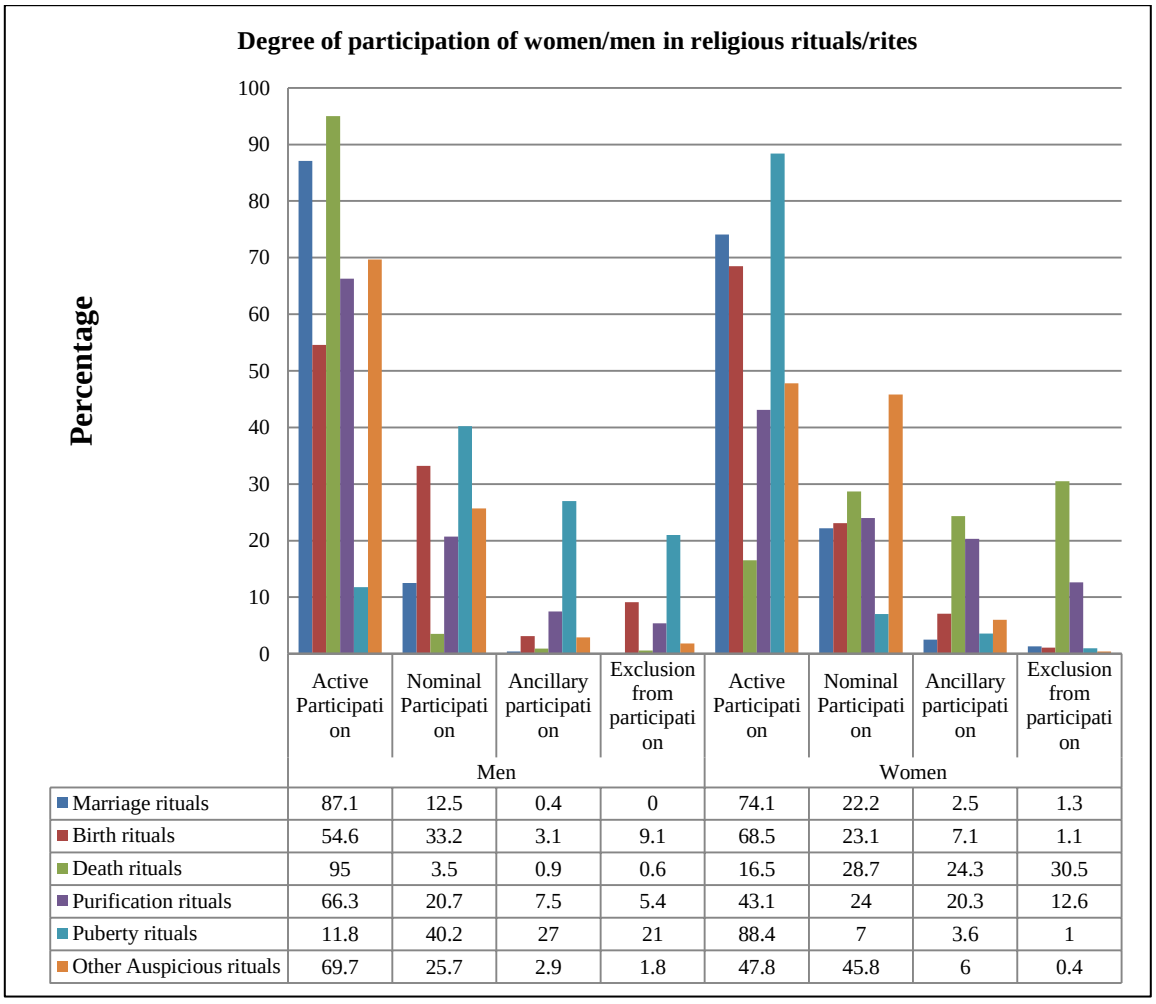
Thus, religion is an important socio-cultural determinant of the status and power that men and women yield in society. Spurred by the assumption that unrestricted participation in religious rituals is an indicator of the status and power bequeathed on one enjoying such prerogative, the study closely inspected the relative participation of men and women in religious rituals of various order. The following Table 11/Figure 9 reflects how religion restricts the participation of women in various religious activities, which at a deeper level is indicative of the low status and negotiability of women induced by religion. The figurative depiction provided below is suggestive of the fact that men preside over most rituals while the participation of women is restrained. In certain kinds of religious activities like that of puberty and birth rituals women predominate while in the other activities the male preponderance is amply reflected

(particularly the death and purification ritual which in traditional societies are exclusive domains of the men). In all rituals of consequence, in other words in religious activities of higher order the monopoly of men is evident while the women's restrained participation in such religious events resounds the inferior status accorded to women.

Table 11: Relative Participation of Men and Women in Religious Rituals

Gender	Participatory approach	Marriage rituals %	Birth rituals %	Death rituals %	Purification rituals %	Puberty rituals %	Other Auspic--ious rituals %
Men	Active Participation	87.1	54.6	95	66.3	11.8	69.7
	Nominal Participation	12.5	33.2	3.5	20.7	40.2	25.7
	Ancillary Participation	0.4	3.1	0.9	7.5	27	2.9
	Exclusion from Participation	0	9.1	0.6	5.4	21	1.8
Women	Active Participation	74.1	68.5	16.5	43.1	88.4	47.8
	Nominal Participation	22.2	23.1	28.7	24	7	45.8
	Ancillary Participation	2.5	7.1	24.3	20.3	3.6	6
	Exclusion from participation	1.3	1.1	30.5	12.6	1	0.4

Figure 9: Relative Participation of Men and Women in Religious Rituals



	Men				Women			
	Active Participation	Nominal Participation	Ancillary participation	Exclusion from participation	Active Participation	Nominal Participation	Ancillary participation	Exclusion from participation
Marriage rituals	87.1	12.5	0.4	0	74.1	22.2	2.5	1.3
Birth rituals	54.6	33.2	3.1	9.1	68.5	23.1	7.1	1.1
Death rituals	95	3.5	0.9	0.6	16.5	28.7	24.3	30.5
Purification rituals	66.3	20.7	7.5	5.4	43.1	24	20.3	12.6
Puberty rituals	11.8	40.2	27	21	88.4	7	3.6	1
Other Auspicious rituals	69.7	25.7	2.9	1.8	47.8	45.8	6	0.4

The argument pursued here is that the relegation of women to an inferior status would impact their self-salience and self-esteem which could have an impact upon their overall mental well-being. The women perform supplementary roles in religious rituals while men are entrusted with core responsibilities. Further, religion educates women to remain submissive to their male counterparts and imposes several other restrictions on them with regard to inheritance of paternal property, choice of partner in marriage, lifestyle in widowhood and other paraphernalia of their social life. All these lead women to internalize the inferior status accorded by religion which negatively impacts self-esteem. Thus, religions and their doctrines assume the role of stressors in the lives

of women. At this juncture it may be relevant to refer to a review article by Koenig (2012) where the author, having studied several other articles correlating religion, spirituality and health, stated that religion may exercise a negative influence on self-esteem as the same emphasizes on humility of character. Moreover, Koenig suggested that religion has the potential to exacerbate guilt in individuals who fail to live up to the standards laid out by religion. These individuals, as the author suggests, may tend towards low self-esteem. The idea dwelt upon here is that religion, through the restriction it imposes on women's participation in rites and rituals and through its various injunctions forebodes a negative influence on their self-concept and self-esteem. Mann draws attention to the,

> … empirical studies over the last 15 years which indicate that self-esteem is an important psychological factor contributing to health and quality of life (Evans, 1997 cited in Mann, 2003). Recently, several studies have shown that subjective well-being significantly correlates with high self-esteem, and that self-esteem shares significant variance in both mental well-being and happiness (Zimmerman, 2000 cited in Mann, 2003). Self-esteem has been found to be the most dominant and powerful predictor of happiness (Furnham and Cheng, 2000 cited in Mann, 2003). Indeed, while low self-esteem leads to maladjustment, positive self-esteem, internal standards and aspirations actively seem to contribute to 'well-being' (Garmezy, 1984; Glick and Zigler, 1992 cited in Mann, 2003). According to Tudor (1996 cited in Mann, 2003), self-concept, identity and self-esteem are among the key elements of mental health. (358)

Going by the rationale outlined above, it may be concluded that mental health is significantly affected by self-esteem. A variety of mental disorders have their genesis in low self-esteem. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM IV) throws light on how "negative or unstable self-perceptions are a key component in the diagnostic criteria of major depressive disorders, manic and hypomanic episodes, dysthymic disorders, dissociative disorders, anorexia nervosa, bulimia nervosa, and in

personality disorders, such as borderline, narcissistic and avoidant behaviour" (cited in Mann et al., 2003, 360). Mann informs us that "negative self-esteem is also found to be a risk factor, leading to maladjustment and even escapism. Lacking trust in themselves, individuals become unable to handle daily problems which, in turn, reduces their ability to achieve maximum potential. This could lead to an alarming deterioration in physical and mental well-being. A decline in mental health could result in internalizing problem behaviour such as depression, anxiety and eating disorders" (2003, 360). A lot of research on mental health has revealed a positive relation between low self-esteem and mental disorders like depression. The argument posited here is that religion through its doctrines and practices attempts to establish women as inferior to men, which in turn conditions the way women perceive themselves. The way women are conditioned to perceive themselves would therefore negatively impact their self-esteem. Drawing from what several research works have revealed, it is argued here that lack of self-esteem, arising out of inferior status accorded to women by socio-cultural factors including religion, stand to adversely affect their mental health. The trajectory of argument traced here conjoins the ideas that religion relegates women to inferior status, that the inferior status thus accorded is so logicized in the wraps of religious ideals and injunctions that women naturalize the same and that naturalization of the inferior status weighs upon the mental health of women. Further, many research works have also pointed at the relation between religion and anxiety, where it has been argued that inability to rise up to religious ideals causes anxiety. Women seem to be more affected by the same as the religious injunctions for women are far more stringent and binding upon them (Koenig, 2012). The researcher, therefore, posits the idea that religion is a stressor in the lives of women which contributes towards poor self-esteem and anxiety experienced by them owing to the religious exhortations that regulate women's lives and chastise them for any transgression of the idealized norm of conduct.

On the flip side, however, there exists a bulk of literature on how adherence to religion asserts a positive influence on mental health. Many studies have revealed that reliance on religious principles have helped redeem many an individual suffering from mental disorders such as depression, anxiety, suicidal ideation, alcoholism etc.

Therefore, any sweeping statement with regard to the negative influence of religion on mental health would be erroneous. While religion has its merits especially in offering solace and support to individuals with certain kinds of mental disorders, the present study critically studies those aspects of religions (particularly those that systematically exclude certain groups and individuals – in the present context the women) that surmise about the inferiority of some individuals and groups, consequentially either restricting their engagement in or totally excluding them from core religious activities. The point drawn home is that this restriction or exclusion, as the case may be, is a clear indication of how religion devalues certain individuals and groups. This devaluation has the potential to precipitate low self-esteem and other negative emotions among the women. Low self-esteem generated by a lingering sense of inferiority, as is argued here, is a tell-tale indicator of poor mental health.

Having explored the social factors that act as stressors in the lives of women, the ensuing section studies labeling as a social process that can assume the proportion of a stressor and have a bearing upon mental health, particularly that of women.

3.3 Labeling and its Influence on Mental Health

Scheff (1966) the main proponent of labeling theory, suggests that mental disorder is a label conferred upon individuals by others in their social milieu. Such imputation is occasioned when the concerned individual manifests deviant behavior, which is a behavior that fails to conform to established social norms. The norms, as Scheff explains are fundamental rules that emerge out of everyday social interaction. Violation of these rules (which are taken for granted rules of everyday interaction) is termed by Scheff as residual deviance. Scheff clarifies the concept of residual deviance thus,

> Most norm violations do not cause the violator to be labeled as mentally ill, but as ill-mannered, ignorant, sinful, criminal, or perhaps just harried, depending on the type of norm involved. (Or potential definers

> may deny that the deviance even warrants labelling.) After exhausting these categories . . . there is always a residue of the most diverse kinds of violations for which the culture provides no explicit label. These are unnameable and unthinkable forms of deviance. . . . For convenience these violations are lumped together into a residual category: witchcraft, spirit possession, or, in our own society, mental illness. (1966, 31-34 cited in Fletcher and Reynolds, 1967)

An individual having been accorded the status of being mentally disordered, in time incorporates the gestures and manners of the same and acts out the associated role. The principal contention proffered by Scheff is that mental disorder in many cases is just a label attached to certain individuals rather than psychopathology. Mental disorder, he argues, is a social role and social reaction a critical determinant of the same. To get an insight into Scheff's stance on the subject, his words may be referred to,

> … in a crisis, when the deviance of an individual becomes a public issue, the traditional stereotype of insanity becomes the guiding imagery for action, both for those reacting to the deviant and, at times, for the deviant himself. When societal agents and persons around the deviant react to him uniformly in terms of the stereotypes of insanity, his amorphous and unstructured rule-breaking tends to crystallize in conformity to these expectations, thus becoming similar to behavior of other deviants classified as mentally ill and stable over time. The process of becoming uniform and stable is completed when the traditional imagery becomes a part of the deviant's orientation for guiding his own behavior. (Scheff 1966/1984, 82 cited in Link and Phelan, 2010)

Scheff makes the point that those located at the lower rungs of the society are more vulnerable to being labeled by those at the helm of power; in this regard women who traditionally are at the bottom of the power hierarchy in society are more prone to be

labeled (Rosenfield, 1982). Scheff's argument is rather one-sided as it is built on the denial of disorder, that is to say that it refutes the reality of mental disorder by arguing that the same is no more than a social label that stems from violation of standard social norms. Moreover, Scheff's claim that labeling stabilizes mental disorder has met with severe criticism particularly by the positivists. The study is advertent to the fact that mental disorder is not all about labeling and that its objective reality is irrefutable, nevertheless, in the present context labeling theory does provide a frame of reference to explore how deviation from ascribed social roles may invite being labeled and how being labeled may hazard mental health, a trajectory of thought that the present section ventures into.

The feminists, in particular, have recoursed to labeling theory to explain the over-representation of females in mental health statistics. They argue that patriarchal authority, which is largely responsible for attaching labels to women, label the same as mentally disordered when they fail to conform to stereotypical gender roles as mothers and wives (Roger and Pilgrim, 2005). Chesler (1972) stated how women who fail to deliver feminine roles scripted by society are generally labeled as mentally disordered. In a similar vein, Rosenfield (1982) expounds on how violation of gender specific roles evokes social castigation. She states that when the women deviants (also men for that matter) reflect behavior that conforms to the socially stipulated sex role, they meet with less severe social reaction than they do when their behavior is inconsistent with the same. In her words,

> … when women deviate in ways that are consistent with the masculine sex role and are more typical of men, the reaction to them is more severe than to men with the same behavior… In sum it is proposed that societal reaction is more severe for "deviant" deviance than for deviance that is consistent with traditional sex-role expectations…With respect to mental disorders, "deviant" deviance refers to psychiatric disorders that are more consistent with expectations for the opposite sex. (Rosenfield, 1982, 19)

To substantiate the argument that deviation from standardized sex role courts social expostulation, Rosenfield refers to studies in criminal behavior conducted by Bernstein et al. (1977) "which has revealed that women who commit crimes which are more typical of men, such as assault, are punished more severely in terms of being convicted of more serious charge, than are men committing the same crime" (19). Thus it is pretty much evident that violation of normative roles, especially socially stipulated gender roles, attracts negative social reaction and often those deviating from the standard, so to say, are labeled as mentally disordered (Scheff, 1966; Chesler, 1972).

As outlined in the previous chapter, data for quantitative analysis has been collected from nine (9) districts of Assam. Alongside the data collected for quantitative analysis a few cases were also generated to study certain relevant aspects of women's mental health. Of the several cases, one case conspicuously reflects the claims made by labeling theory. The case is reflective of how perceived deviation from sex role has caused the subject to be labeled as mad and how this label has elicited negative coping strategy in the same.

Case Illustration I

Basudha is a woman in her late 40s, who resides in a village named Habidoloni in Sootea Block of Sonitpur district. The villagers call her Basudha *pagoli* (Basudha, the mad woman). She is an unmarried reclusive woman who lives with her ailing brother. Her brother, a school teacher, is a frail arthritis patient who is looked after by Basudha. She was identified with the help of a local Anganwadi worker (state appointed community worker who looks into rural mother and child health issues) who narrated Basudha's past to the researcher. Basudha and her brother were raised in poverty by their parents. After their mother's demise, Basudha took charge of the household. Her travail commenced after the death of her father. According to the Anganwadi worker, Basudha's father left behind a humble amount of money he had saved over the years out of which Basudha's uncle claimed a share. Left alone to fend for herself and her brother, Basudha developed an aggressive personality. She assumed the role of the man

of the family as accounted by the Anganwadi worker. She retorted in a brash manner to any perceived intrusion into her family matters, reflected an open aversion for marriage and male company and desisted from taking part in the communal rituals that women of the village generally participated in. Her personality and behavior evoked negative social response; the villagers retorted at her by calling her *pagoli* or mad. It becomes apparent that Basudha's personality was in striking contrast to the docile, dependent, soft-spoken, amenable to marriage and motherhood conventional feminine imagery which led her to being labeled as *pagoli* or mad.

While labeling theory asserts that labeling stabilizes one as mentally disordered, modified labeling theory looks at consequence of labeling. According to the modified version of the theory, labeling impacts on the individual's self-concept, in other words, how one perceives oneself. Two aspects of self-concept that are largely effected by labeling include self-esteem, which is the evaluative aspect of self-concept (Shavelson & Bolus, 1982 cited in Pasman, 2011) and self-efficacy, which is one's subjective feeling of competence, the idea that one is capable of exerting control over her/his environment (Bandura, 1997 cited in Pasman, 2011). Labeling theory describes the negative impact of labeling on self-esteem and self-efficacy. The negative reactions one receives owing to the attached label impairs one's self-concept and self-efficacy and impels the same to recourse to non-adaptive coping responses such as secrecy, withdrawal or preventively educating others about her/his mental disorder. In the present case the subject recoursed to withdrawal mechanism. Withdrawal bears upon social network ties and leads to insular support networks comprising mainly of household members (Link and Phelan, 2010), which is what had happened in the case of Basudha as well.

Over the years Basudha had become reclusive. Owing to the negative reaction and exclusion she faced from the society. She had withdrawn from social interaction and largely lived in the seclusion of her home. It may be argued here that her self-concept was severely jolted by the reaction she received from the society owing to which she had retracted into a shell. She turned away the researcher who attempted to speak to her

on several occasions. Her brother, however, spoke to the researcher and accounted for the mental ordeal that Basudha was faced with when the villagers alleged her to be mad. To him Basudha assumed an aggressive personality in the face of the threats she received from their uncle, the brother of their deceased father. The demise of their father and his own sickness, which robbed him of physical strength, had made them vulnerable to hostile forces such as their uncle who had an eye on their father' savings. In order to fend off hostile forces Basudha had to stand strong, he said. However, her demeanour was unacceptable to the patriarchal society that had defined roles becoming a woman. By the established standards, Basudha was a deviant and therefore courted the label of *pagoli* (mad woman). She, in her own right, coped with the offensive situation by adopting the withdrawal mechanism and isolating herself from her community.

It is indeed difficult to make a sweeping statement, consistent with that of labeling theorist Scheff, that being labeled as mentally disordered impels the labeled to internalize the symptoms of mental disorder and manifest the same in their own behavior. That is to say, that labeling drives one to assume the role of the mentally disordered. Nevertheless, it is argued here that the process of labeling is indeed a stressor that makes the labeled vulnerable to scathing social reaction which, in turn, negatively impacts upon their mental health, their social interaction and the overall quality of their life, as has been observed in Basudha's case.

Discussion on labeling and its impact on mental health without referring to the process of stigmatization renders the portrayal incomplete. In fact, labeling is a phenomenon that is wrapped within the process of stigmatization. In this context, it may be apt to refer to Bruce who expounds the course of stigmatization (and how labeling is subsumed in the process) in his conference paper, *The Stigma Process: Re-conceiving the Definition of Stigma,* submitted to the American Public Health Association in 2000,

> We conceptualize stigma as a process. It begins when dominant groups distinguish human differences – whether 'real' or not. It continues if the observed difference is believed to connote unfavorable information about

> the designated persons. As this occurs, social labeling of the observed difference is achieved. Labeled persons are set apart in a distinct category that separates 'us' from 'them.' The culmination of the stigma process occurs when designated differences lead to various forms of disapproval, rejection, exclusion and discrimination. (cited in Rogers and Pilgrim, 2005, 27)

A mutually exclusive and isolated treatment of labeling and stigma respectively may therefore be contested. However, the present chapter deals with the two aspects separately but does not assume any organic distinction between the two. Rather, the intent here is to study the process of labeling in its own right to gauge its impact on mental health of the labeled. Therefore, labeling has been studied along with other social stressors in order to understand the mental distress that this process induces. Stigma is studied in a separate section to inquire into the social repercussions that women with mental disorder are confronted with.

The people suffering from mental disorders are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of our society (Johnstone, 2001 cited in Overton and Medina, 2008). Negative connotations and false assumptions shrouding the understanding of mental disorders causes as much harm as the disease itself (Overton and Medina, 2008). Stigma attached to those with mental disorders defines the course of the illness as well as the consequence of the same for the individual concerned. In the following section the impact of stigma attached to those with mental disorders is elaborated upon.

3.4. Social Consequence of Mental Disorder

The sections presented above have attempted to explore the causal effect of social stressors on mental disorders. The present section seeks to enquire into the social consequence of mental disorder. Put in other words, this section dwells on the social response towards those suffering from mentally disorders. Mental disorder conjures negative imagery, those suffering from mental disorders are commonly perceived as

irrational, dangerous, immoral, perverse, worthless etc. and therefore evoke negative social reactions Society, historically, has had little space for those presumed to be deviating from the normative mainstream of thought, conduct and self-expression. Therefore the mentally disordered, who fail to keep up with normative expectations, meet with scathing social reaction. As Rogers and Pilgrim put it "The fear and distrust of madness historically is deeply ingrained. Also modern societies place a high value on rationality and so demonstrable irrationality may be used as a warranted basis for social rejection and invalidation" (2005, 37). The mentally disordered are stigmatized and banished to the fringes of society, with the consequence that both their personal and social lives are hamstrung. This section aims at probing into the affect that stigma has on the lives of those with mental disorder, particularly women with mental disorder. The understanding of stigma has largely been drawn from Goffman (1963), who explains the same as a discrediting attribute and stigmatized individual as one who is differentiated from the normal members of the society. The stigmatized self emerges when there exists a dissimilitude between one's social identity (what the society expects of a person) and actual identity (what the person actually is). Such an identity, which is discordant with social expectations, is termed by Goffman as spoiled identity and, as explained by him, attracts stigmatization. Stigma, as conceived by Goffman is applicable not just to the mentally disordered but to a range of individuals who are perceived as deviating from the norm or acceptable standards of a society (including criminal offenders, the disabled, drug addicts, homosexuals etc.). Stigma, as has been conceptualized by Goffman, is socially constructed by patterns of interaction and is fashioned according to the norms and standards of the given social context in which it operates. While men and women both are susceptible to being stigmatized, the present section explores stigma in relation to women with mental disorder. In the context of women, it is argued that, they are expected to perform socially ascribed roles particularly related to bearing and rearing children and to upholding the moral and cultural values of society. Mental disorders which may incapacitate them from performing the expected roles may lead to their stigmatization which negatively impacts the course of their lives.

3. 4. 1 Stigma and its Impact on Lives of the Mentally Disordered

Stigma may be understood as "the situation of the individual who is disqualified from full social acceptance" (Goffman, 1963, 9). While stigma may be attached to any behavior perceived as deviant, mental disorders are among those conditions that are most stigmatized (Scheyett, 2005 cited in Buck, 2013). It has been observed by many researchers that generally people are disapproving of persons with psychiatric disabilities significantly more than persons with physical disorders (Corrigan et al., 2000; Socall and Holtgraves, 1992; Weiner and Magnusson, 1988 cited in Corrigan and Watson, 2002). Severe mental disorder has been equated with drug addiction, prostitution, and criminality (Albrecht and Levy, 1982; Skinner et al., 1995 cited in Corrigan and Watson, 2002). Unlike physical disabilities, individuals with mental disorders are perceived by people to be in control of their disabilities and responsible for causing them (Corrigan et al, 2000; Weiner and Magnusson, 1988 cited in Corrigan and Watson, 2002). People with mental disorders have to bear dual burden, on one hand they have to lumber with the symptoms and disabilities of the condition on the other they have to live with a stigmatized identity (Corrigan and Watson, 2002). Stigma has a discrediting and dehumanizing impact on individuals as is expressly articulated in the words of Goffman who opines that stigma,

> … reduces the bearer . . . from a whole and usual person to a tainted, discounted one . . . We believe that a person with a stigma is not quite human . . . We tend to impute a wide range of imperfections on the basis of the original one . . . We may perceive his (sic) defensive response to his situation as a direct expression of his defect... (1963, 14–16)

Stigma impacts an individual at personal, professional and social level and fetters the same from optimal realization of life opportunities. Stigma has three important components *viz*. stereotypes, prejudice, and discrimination through which it operates. Stereotyping is a micro-sociological phenomenon that refers to human propensity to

impute fixed and common characteristics to the whole social groups. It is a kind of social typing that ignores individual variability by subscribing to narrow set of ideas (Rogers and Pilgrim, 2005). Prejudice gets manifested in negative attitudes directed towards individuals/groups on whom derogatory or pejorative stereotypes are applied. Prejudice culminates in discrimination which is the behavioural component of stigma and takes place when people act on the basis of prejudiced attitudes or beliefs (Ciftci, 2012). The stigmatized person is set apart from other members of society; depersonalized, demoralized and rejected the person acquires what Goffman (1963) terms as spoiled identity. Buck (2013) cites Link and Phelan (2001) to explain the emergence of stigma on the basis of five interrelated components. First component relates to distinguishing and labeling individuals/groups on the basis of differences (from the normative) in their attributes and characteristics, while the second links these differences to negative stereotypes. The third component places the labeled individuals/groups in categories that distinguish them from the 'normal' members of the society. The fourth component reflects both status loss and discrimination of labeled individuals, leading to unequal outcomes and the fifth pertains to the manifestation of stigma.

Link and Phelan (2001) point out at three significant outcomes of stigmatization, viz. loss of social status; structural discrimination and damaging coping strategies adopted by the stigmatized (Buck, 2013). Other scholars have further elaborated on the same. Discrimination that stems from stigma have been found to assume one of the forms delineated here, that is, social distance, withholding help, coercive treatment or segregated institutionalization. Several studies have revealed that the most telling consequence of stigma is social avoidance which leaves a negative imprint on vital aspects of the stigmatized individual's life, such as her/his prospect of marriage (Martin et al., 2000 cited in Corrigan and Watson, 2002) and employment (Link, 1987, Bordieri and Drehmer, 1986; Link, 1982; Wahl, 1999 cited in Corrigan and Watson, 2002), accessibility to social amenities (Segal et al., 1980 cited in Corrigan and Watson, 2002) and socializing network . Thus, those suffering from mental disorders are robbed of opportunities to live a wholesome life (Corrigan and Watson, 2002). Buck (2013) refers

to Scheyett (2005) to trace how attitude towards those with mental disorder is formed. He cites the following three components that shape attitude towards the mentally ill.

- authoritarianism (the belief that individuals with a serious mental illness are irresponsible and worthless and lack the ability to make life decisions)
- benevolence (the view that people with mental illnesses are helpless and childlike)
- fear and exclusion (the conviction that people with mental illnesses are dangerous and need to be isolated from society)

Fear is the most dominant instinct evoked, by those suffering from mental disorders, in the minds of people as the former are assumed as dangerous and violent (Scheyett, 2005 cited in Buck, 2013). People not only fear violence, but also fear the unknown and the unpredictable which enhances the stigma and discrimination attached to mental disorders. The prejudice harboured against mental disorder is such that respondents', as recorded in few studies, have stated that the two worst conditions that could afflict an individual are leprosy and insanity (ibid.).

The points elucidated above are applicable in the case of both men and women. In the context of the women, the view may be forwarded that patriarchal society is relatively more intolerant of the failings of women than that of men and the social ideals women are expected to live up to are more stringent in their application to the latter. Symptoms of mental disorder interfere with women's role performance as wives, mothers, care givers and embodiments of social moral values. Society in general is more judgmental on the conduct, character and presumed deviances of the women. Therefore, the spoiled identity acquired by them on account of their condition calls for witheringly scornful reactions. Moreover, the social space offered to stigmatized women is far more constricted in comparison to that of the men. The lack of social support and resources further worsens their situation. In traditional societies the life prospects of women largely center around marriage and child bearing. Men with mental

disorders may be able to enter into marital relationships and their wives may be obliged to care for them as their natural duty. However, women with mental disorders are faced with zero prospect of marriage. Those that develop symptoms post marriage, are more often than not, abandoned by their partners. The women bear the brunt of stigmatization more intensely than the men, which is reflected in myriad aspects of their lives.

The present study has explored the consequence the women with mental order are faced with by probing 830 female respondents on the matter. The opinion of the respondents were sought on how being identified with mental disorder affected different aspects of women's personal and social life. The study ventured deeper into the terrain in order to gauge how having a person with mental illness in the household eclipsed the prospects of other family members as well. Thus a comparative study was made between the prospects of women suffering from mental disorders and that of their family members. The data analysed has brought out the fact that family members of women suffering from mental disorders do suffer some set-back in fulfilling their life prospects; however, the same did not achieve conspicuous proportions. In case of the women suffering from mental disorders, the respondents vociferously claimed that the same are stigmatized owing to which their life prospects are significantly affected. Of the total number of respondents, 67.9% vouched for the fact that women with mental disorders suffer social isolation; 53.6% opined that such women are confronted with dwindling prospect of marriage; 58.7% reflected on the impediments they face to get employed; 44.6% of the respondents asserted that women with mental disorders are largely excluded from participation in social activities and 63.7 % respondents supported the view that women with mental disorders face an overall set back in social status, thereby endorsing the argument provided above that stigma attached to women suffering from mental disorders has serious implications on their life prospects. Table 12 (a-e)/Figure 10 (a-e) provided hereunder are figurative depictions of the argument mooted here.

Table 12a: Isolation of Women with Mental Disorders vs. that of their Family Members

	Family members are isolated		
Women with mental disorder are isolated		**Yes**	**No**	**Total**
	Yes	23.1%	44.8%	67.9%
	No	4.7%	27.3%	32.0%
Total		27.8%	72.2%	100.0%

Figure 10a: Isolation of Women with Mental Disorders vs. that of their Family Members

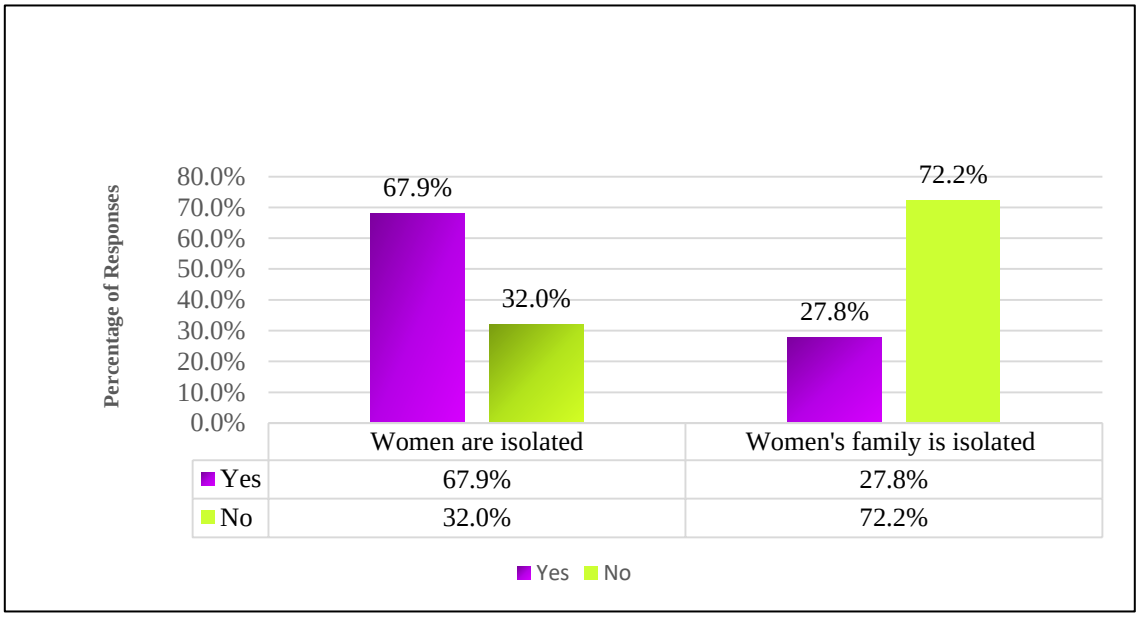


Table 12 b: Marriage Prospects of Women with Mental Disorders vs. that of their Family Members

		Marriage prospects of family members			Total
		No prospect	Limited/Reduced prospect	No change in prospect	
Marriage prospects of women with mental disorders	**No prospect**	3.5%	32.8%	17.2%	53.6%
	Limited/Reduced prospect	5.4%	17.2%	11.0%	33.7%
	No change in prospect	1.1%	2.5%	8.3%	12.1%
Total		10.0%	52.5%	36.6%	100.0%

Table 10 b: Marriage Prospects of Women with Mental Disorders vs. their Family Members

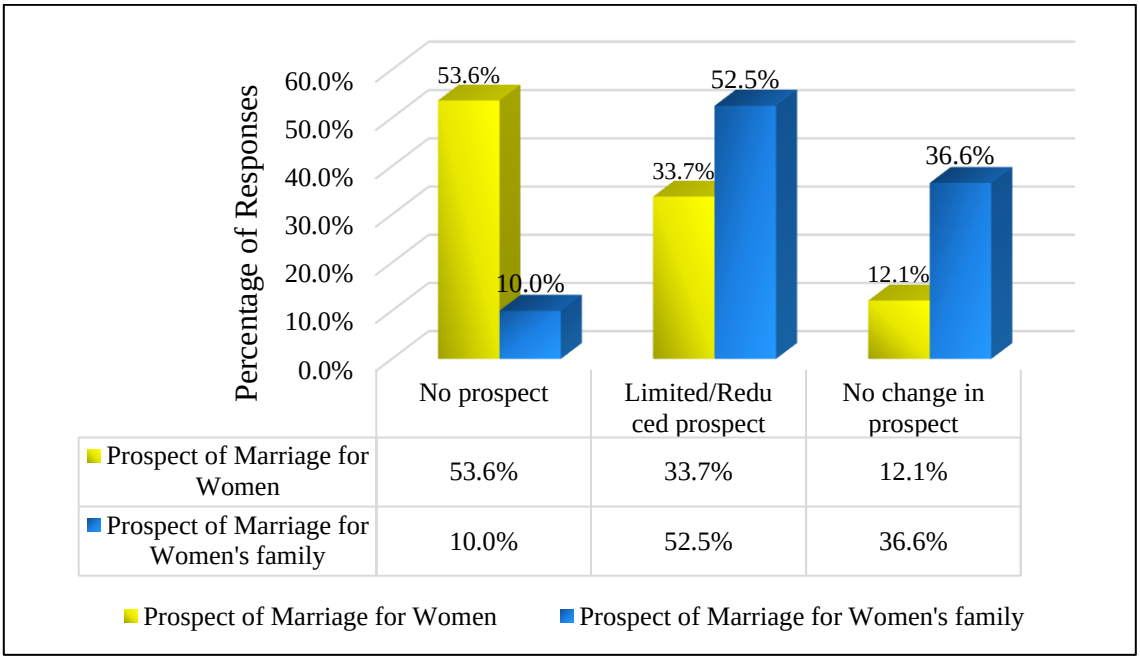


Table 12 c: Low Social Status of Women with Mental Disorders vs. that of their Family Members

		Low Social Status of family members			Total
Low social status of women with mental disorders		Yes	No	Same as Before	
	Yes	26.5%	16.6%	20.7%	63.7%
	No	4.5%	4.6%	11.0%	20.1%
	Same as Before	1.0%	.7%	14.3%	16.1%
	Total	32.0%	22.0%	46.0%	100%

Figure 10 c: Low Social Status of Women with Mental Disorders vs. that of their Family Members

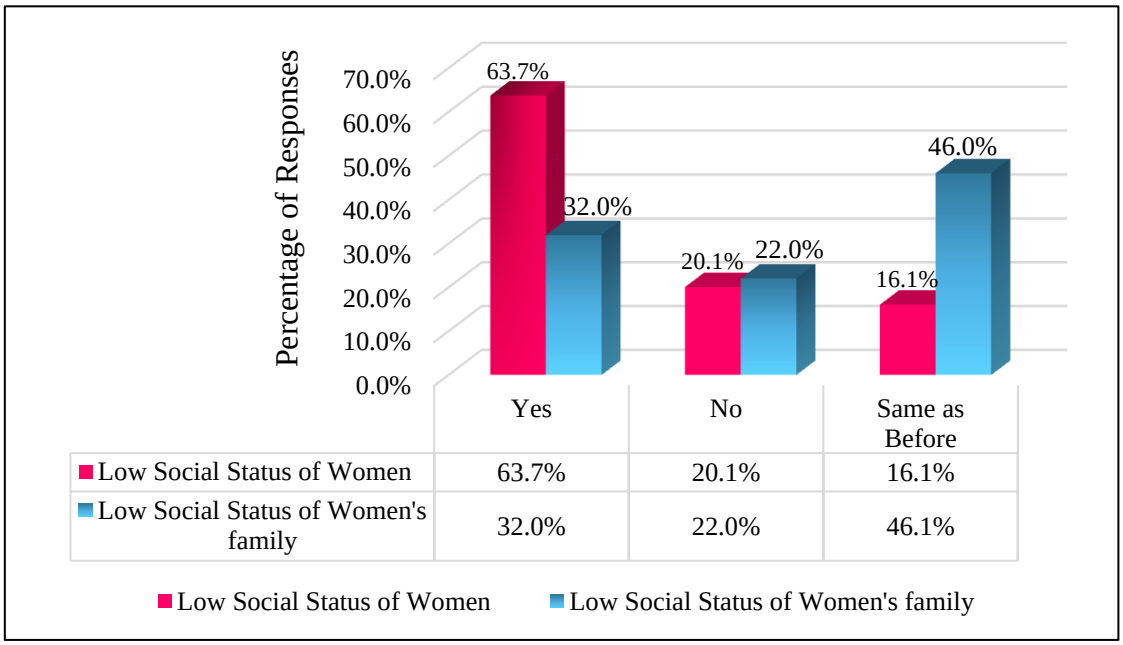


Table 12.d: Participation in Social Activities by Women with Mental Disorder vs. that of their Family Members

		Participation in Social activities: family			Total
		No Participation	Reduced Participation	Same as before	
Participation in Social activities: women with mental disorder	No Participation	6.3%	15.2%	23.1%	44.6%
	Reduced Participation	2.7%	16.1%	15.5%	34.1%
	Same as before	1.0%	2.9%	17.2%	21.1%
Total		10.0%	34.2%	55.8%	100.0%

Figure 10.d: Participation in Social Activities by Women with Mental Disorder vs. that of their Family Members

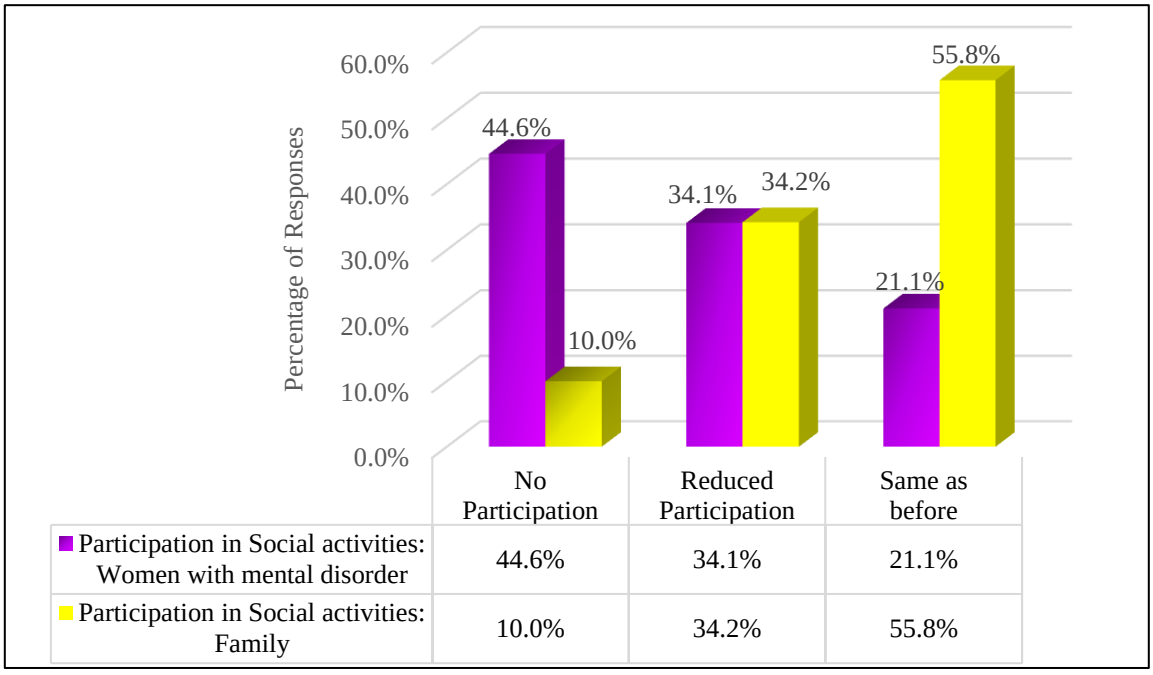
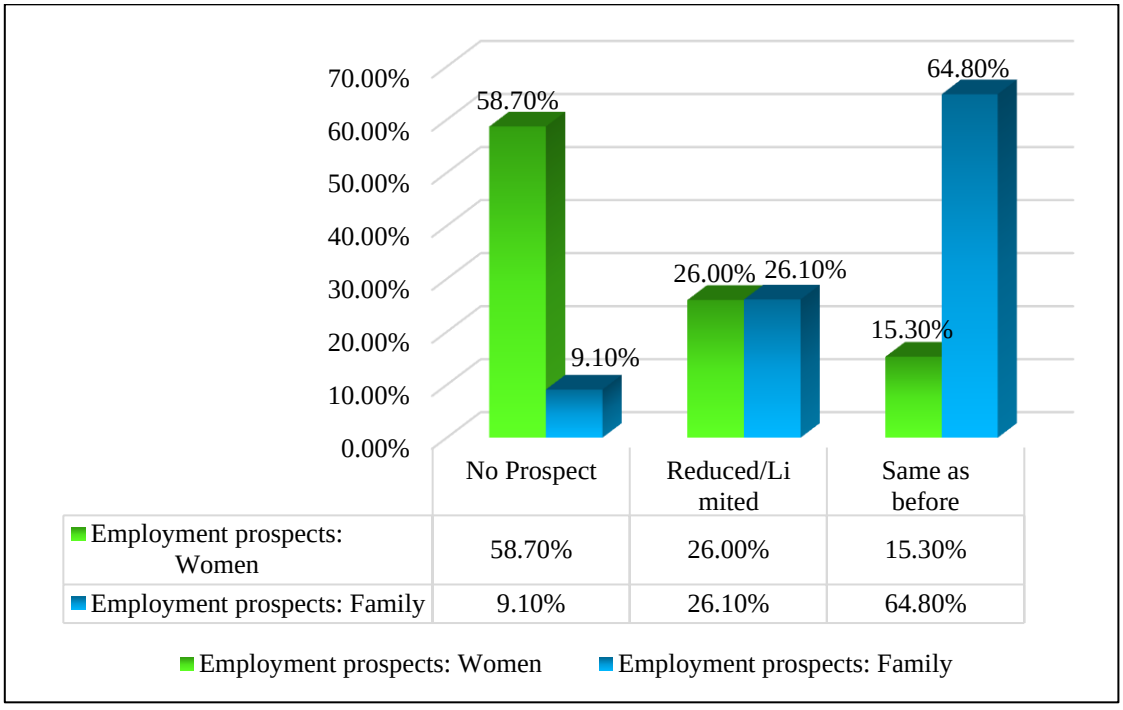


Table 12 e: Employment Prospects of Women with Mental Disorders vs. that of their Family Members

		Employment prospects: family members			Total
		No Prospect	Reduced/ Limited	Same as before	
Employment prospects: women with mental disorders	No Prospect	5.1%	17.8%	35.8%	58.70%
	Reduced/Limited	1.0%	6.0%	19.0%	26.00%
	Same as before	3.0%	2.3%	10.0%	15.3%
Total		9.1%	26.1%	64.8%	100.0%

Figure 10 e: Employment Prospects of Women with Mental Disorders vs. that of their Family Members



Owing to the stigmatized status heaped on individuals, the latter have often been observed to give in to self-stigma, a process whereby the stigmatized individual/group internalizes the public prejudice. Self-stigma entails the following elements:

- Awareness of the stereotypes associated with mental disorder
- Agreement with the prevalent stereotypes
- Application of the stereotypes on self
- Harmful implication of the above on one's self-esteem and self-efficacy (Corrigan, Larson, & Kuwabara, 2009 cited in Ciftci, 2013)

Self-stigma can be significantly harmful in as much as it forecloses important life pursuits of individuals who internalize the notion that they should not pursue goals that society thinks they cannot succeed in (Corrigan, Larson, & Rusch, 2009 cited in Ciftci, 2013). In this context Goffman clarifies that the stigmatized individual perceives rejection she/he faces as a consequence of her/his failure to live up to social expectations and therefore internalizes this denial of acceptance as brought about by personal failure,

> The central feature of the stigmatized individual's situation in life can now be stated. It is a question of what is often, if vaguely, called "acceptance." Those who have dealings with him fail to accord him the respect and regard which the uncontaminated aspects of his social identity have led them to anticipate extending, and have led him to anticipate receiving; he echoes this denial by finding that some of his own attributes warrant it. (1963, 8)

While public stigma creates barriers for the stigmatized individual in optimally realizing life opportunities, self-stigma creates internal barriers within the individual which impedes the same from optimal realization of her/his potential. Thus, public-stigma and self-stigma work in tandem to thwart the realization of life opportunities and potential inherent in stigmatized individuals. Self- stigma may be more intense in the case of the women who tend to internalize their emotions, as has been discussed earlier.

Women reflect the tendency to blame themselves for the problems they are faced with in their lives (Jackson 1962 cited in Busfield, 1996), therefore, when accused of non-compliance with normative standards and of personal inefficacy, women are most likely to internalize the same within themselves and succumb to the process of self-stigmatization.

Though stigma may share certain features across socio-cultural contexts, it is largely shaped by the norms of the local social world. Thus, the cause and course of stigma in a given society would depend on the values of the local context rather than having a universal appeal (Klienman et al., 2009). Whether in the context of the women or for that matter the men, what is conceived as normal and socially acceptable is determined by the dynamics of the local context, therefore what stands to be stigmatized is specific to its context.

Summation

The present chapter is a pandect of the myriad social factors that impact mental health, particularly that of women. Stressors such as marriage, economic deprivation, religion have been studied in the context of women's mental health. Each of these factors has been found to be unfavourably disposed towards women and as the genesis of non-organic common mental disorders among them. Labeling has been explored as a stressful process in order to understand how perceived deviance from social standards incites social acrimony; with the consequence that the deviants are alienated from the general rung and labeled (more often than not) as mentally disordered. The impact of this process of labeling on women's mental health has been studied in this chapter. Further, an attempt has been made in this chapter to study how mental disorder impinges on the quality of life of the mentally disordered women. The design of the chapter has been to provide an overview of the impact of varied social stressors on women's mental health and the social consequence that the mentally disordered women are faced with. The following chapters would study in details two important aspects of women's mental health. The subsequent chapter would explore the impact of violence,

which is posited as one of the major stressors in the lives of women, on the mental health followed by the penultimate chapter of the study that would delve into certain forms of dissociative behaviours as symbolic expression of cumulative distress women experience along the trajectory of life.

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