CHAPTER -1

Introduction

Studies on mental health have, of late, courted much attention. The last few decades have witnessed an increase in academic as well as non-academic explorations on the cause, course and consequence of mental disorders; largely as a result of a growing awareness of the magnitude of mental disorders world-wide and the socio-economic burden the same poses. *Investing in Mental Health*, a document produced by the Department of Mental Health and Substance Dependence, Non-communicable Diseases and Mental Health, World Health Organization (2003), has categorically spelt out that across the global scape 450 million people suffer from mental or behavioural disorders. Further, four out of six leading causes of global disability include neuropsychiatric disorders which account for 30.8% of total disability and 12.3% of the total burden of disease. This figure, however, is expected to rise to 15 % by the year 2020 (WHO, 2001). It has been estimated that neuropsychiatric conditions alone contribute to 13% of disability adjusted life years (DALYs). Moreover 150 million persons suffer from depression at any point in time; almost 1 million people commit suicide every year; another 25 million people suffer from schizophrenia, 38 million suffer from epilepsy; and more than 90 million suffer from disorders resulting from substance abuse. The document also mentions that the cost of mental health problems in developed countries is estimated to be between 3% and 4% of their GNP (WHO, 2003). "This growing burden amounts to a huge cost in terms of human misery, disability and economic loss" (WHO, 2003, 8). Kessler et al. have referred to the WHO World Mental Health survey conducted on 28 countries to emphasize on the global burden of mental disorders and the societal cost the same indicates at. The sparcity of adequate state policies and treatment and/or rehabilitation facilities in the face of this burgeoning problem implies a wide range of adverse life course outcomes which may be viewed as societal costs of these disorders, such as reduced educational attainment, thwarted prospects of marriage, reduced employment opportunity and low economic status (2009). "The economic impact of mental disorders is wide ranging, long-lasting and large. Measurable causes of economic burden include health and social service needs, impact on families and care givers (indirect costs) lost employment and lost productivity, crime and public safety,

and premature death" (WHO, 2001, 16). Apart from the direct cost of mental health which incurs on account of treatment provisions, the indirect cost owing to the loss of productivity of those disabled by mental disorder adds to the overall cost. The statistics cited above aptly summarize the enormity of the issue and the attention it therefore warrants.

The burden of mental disorders is just as overwhelming in the Indian context as it is anywhere else in the world. It has been estimated that in India approximately 20 to 30 million people are afflicted with mental disorders and are in need of appropriate treatment. As estimated by a meta-analysis of thirteen (13) epidemiological studies the prevalence of mental disorder in India is 58.2 per 1000 population. Importantly, this study throws light on the fact that around 1.5 million people in India suffer from severe mental disorders and 5.7 million suffer from an array of milder psychiatric disorders (Reddy and Chandrashekar, 1998). However, institutional capacity in India is grossly inadequate to respond to this need with only 3500 psychiatrists, 1000 psychiatric social workers, 1000 clinical psychologists and 900 nurses in the country (Murthy, 2011).

The global burden of mental disorder warrants that adequate resources be allocated and effectively used to address the existing treatment gap of 75%, a situation which is particularly pertinent in the context of the low and middle income group countries (WHO, 2008 cited in Sinha and Kaur, 2011). At present lack of awareness about mental disorders, inaccessibility to institutional treatment and stigma associated with the same in the face of high prevalence of mental disorder globally merits the attention of the academicians, the activists and the policy makers alike in order that the issue be appropriately addressed and the socio-economic cost of the same be reduced (Sinha and Kaur, 2011).

1.1 Understanding Mental Health and Illness

A layman's cogitation on mental health would reflect upon the same as the absence of psychopathologies, such as depression and anxiety. However, the term mental health

connotes a wholesome state of mind that conduces rational thinking, effective communication, learning, emotional development, resilience and a sense of self-worth. To gain a comprehensive insight into what mental health is one may recall the World Health Organization's definition of health (and mental health),

> A state of complete physical, mental and social well-being and not merely the absence of disease which refers to myriad activities directly or indirectly related to the mental well-being of an individual. Mental health may broadly be defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. (WHO, 1948, 100)

In this respect, the predominant conception of mental health as solely and wholly an absence of disease is dispelled. Health historically has been conceptualized in three ways. Firstly, as *pathogenic* (derived from the Greek word *pathos* meaning suffering) which views health as an absence of disease. Secondly, as *salutogenic* (derived from the Latin word *salus* meaning health) which views health as marked by the presence of positive states of human capacities and functioning in terms of thinking, feeling and behaviour (Str¨umpfer, 1995 as cited in Keyes and Michalec, 2010). Thirdly, health is gestated as a holistic state derived from the ancient world *hale* meaning whole. “This approach is exemplified in the World Health Organization’s (1948) definition of overall health as a complete state, consisting of the presence of the positive state of human capacities and functioning as well as the absence of disease or infirmity” (Keyes and Michalec, 2010, 126). Mental illness, on the other hand refers to conditions generally characterized by dys-regulation of mood, thought, and/or behaviour, as recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV). In the parlance of medical science, mental illness is a medical condition that debilitates a person’s thinking, feeling, mood, ability to relate to others and daily functioning. To draw a parallel, just as physical illnesses are disorders of the

human physiological system, mental illnesses are disorders of the mind that, as commonly understood, diminishes an individual's capacity for coping with the everyday mundane demands of life.

The two models discussed below offer two important perspectives in conceptualizing mental health and illness

1.1.1 The Two Continua Model

Mental health, in more explicit terms, may be understood as "…state of successful performance of mental function, resulting in productive activities, fulfilling relationships with people and the ability to adapt to change and to cope with adversity" (U.S Department of Health and Human Services, 1999, 4 cited in Keyes, 2002). For long, sociologists have advocated in favour of a definition of mental health that rises above a narrow assumption of the same as simply an absence of mental illness; because in academic as well as lay use, the term continued to be misused as no more than an antonym of mental illness (Keyes, 2002). Mental health and mental illness represent two distinctive areas of theory, research and policy implications (Scheid and Brown, 2010); therefore, to define one as merely an absence of the other is to subsume the scope of each category. Keyes explains mental health as a syndrome, a state of health which is indicated "when a set of symptoms at a specific level are present for a specified duration and this constellation of symptoms coincides with distinctive cognitive and social functioning" (Keyes, 2001; Mechanic, 1999 cited in Keyes, 2002, 208). Keyes informs us that for the last four decades or so social scientists have attempted to conceptualize mental health in terms of subjective well-being which may be understood as an individual's personal assessment of her/his affective state and psychological and social functioning. Affective or emotional wellbeing is reflected by the positive feelings one nurtures towards life, whereas the presence of negative feelings is contraindicative in this regard. Another aspect pertinent in understanding mental health as held up by Keyes is psychological wellbeing which is accounted for by factors such as self-acceptance, positive relations with others, personal growth, sense of

purpose in life, control over one's environment and self-determination. Yet another dimension of mental health includes social well-being and may be understood in terms of social coherence, social actualization, social integration, social acceptance and social contribution. Several studies on the domain have asserted that subjective well-being encompasses hedonic well-being (i.e. positive emotions towards one's life) and eudemonic well-being (i.e. psychological and social well-being) (Keyes and Michalec, 2010). The point mooted here is that mental health is a holistic state which is characterized neither by an absence of mental illness, nor by the presence of subjective well-being but a state marked by presence of distinctive mental health symptoms outlined above (2002).

Thus, Keyes grounds the two continua model to explain mental health and mental illness as interconnected but different axes. Drawing the bulk of the argument from Keyes, it can be understood that mental health and illness though related are, nonetheless, distinct dimensions – one continuum indicates the presence or absence of mental health, the other the presence or absence of mental illness. Mental health is therefore best viewed as a state complete in itself, distinguished not merely by the absence of mental illness but also by the presence of mental health characteristics or archetypal features. That is to say that the indicators of mental health are categorically different from the indicators of mental illness (Westerhof and Keyes, 2009). Mental illness, similarly, is characterized by the presence of distinctive syndromes that affect the cognitive as well as behavioural faculties of an individual. Medical practice is based on this two continua approach, whereby the practitioners are attuned to considering health and illness as dichotomous categories. The *Diagnostic and Statistical Manual of Mental Disorder* and most epidemiological studies that explore the severity of mental health in the general population subscribe to this perspective (Scheid and Brown, 2010). The two continua model, also known as the two factor model, supports the complete state approach, that is, the envisioning of mental health as a holistic state characterized by designated features of health and not simply denoted by an absence of pathology or illness (Keyes and Michalec, 2010). Keyes has further distinguished *flourishing* as a

state when individuals exhibit optimal level of subjective well-being, psychological and social functioning (that is a state of optimal mental health) from *languishing* which he explains as a state of being where individuals reflect low levels of subjective well-being along with low levels of psychological and social functioning (that is a state of optimal mental illness). Those individuals who are not located at either of the two poles of the continuum, that is neither *flourishing* nor *languishing*, are considered to possess moderate mental health (2002).

1.1.2 Mental Health and Illness Continuum Model

Another approach with regard to mental health and illness which merits attention is the one that suggests that health and illness are parts of a single continuum, with health and illness at opposite ends of the same pole and that most individuals are located somewhere in between the two points. The continuum perspective, therefore, suggests that there are varying degrees of healthy and sick, normal and abnormal. The obvious difference between the present model and the two continual model discussed above is that whereas the latter emphasizes on health and illness as two distinctive categories, the former traces the spectrum between health and illness as overlapping grey areas. The distinction between health and illness is not as sharp in this model, rather the boundaries of each category merge and blend into each other. Several researchers rely on this approach and employ continuum assessments of mental health and mental health problems such as scales that assess psychological well-being or distress and also the severity and frequency of the same along the continuum (Mirowsky and Ross, 2002 cited in Scheid and Brown, 2010). The spectrum suggests that a movement in both directions along the continuum is possible. That is, along the course of life an individual may reflect varying degrees of mental health and illness and that life events have a role to play in affecting mental health of individuals either positively or negatively. In this regard, Scheid and Brown inform us that "the psychosocial model of mental illness, dominant until the 1970s, was based on a continuum definition of mental health and illness in which the boundary between health and illness was fluid and subject to social

and environmental influence. That is, it was widely accepted that anyone could become "sick" if subject to the right conditions or environmental stressors" (2010, 3-4). Also known as the single factor model, this approach suggests that "the measures of mental health and mental illness reflect a single latent factor, support for which would indicate that the absence of mental illness implies the presence of mental health" (Keyes and Michalec, 2010, 128).

The present research aims to study mental health of women in order to gauge the aetilogical role of socio-cultural factors. The intent here is to study how the overall mental health of women is affected by the vagaries of their social circumstances. In building the rationale for the study, snippets have been drawn from both the models discussed above. From the two continua model, the study borrows the idea that mental health is a state in itself that is distinguished by its typal characteristics. Notwithstanding the influence of the two continua model on the present study, the same also reflects its affinity for the mental health and illness continuum model principally because it indicates at socio-cultural stressors encountered by individuals along the trajectory of their lives as crucial moderators of mental health and illness.

1.2 Myriad Perspectives on Mental Health

Different schools of thought have conceptualized mental health in different ways. The three dominant perspectives in this regard include the biological, the psychological and the sociological perspectives, which are being discussed below. It may be noted here that the term mental disorder is consciously used in the present section of the chapter to allude to a range of mental health concerns, inclusive of both common mental disorders as well as severe mental disorders.

1.2.1 Biological Perspective on Mental Health

This perspective has an organic or biological genesis and builds itself upon the claim that mental health can be potentially threatened by genetic, biological and neurological

causes. Basically, mental disorder is conceived of in terms of physical disorder that can be cured with the aid of medicines. The prevailing assumption in this regard is that mental disorders can be put through the protocol of clinical testing, diagnosis, and treatment much like disorders of the body. In the 1990s a gush of enthusiasm had swept over the medical domain owing to its purported breakthrough in offering cure to mental disorders, a terrain that had remained challenging to medical science for long. Advances in genomics, neuroscience and molecular biology invigorated this enthusiasm with the presumption that it was well within the reach of medical science to cure mental disorders. In the words of Thomas Insel, Director of National Institute of Mental Health, advances in neuroscience would "lead to more targeted and curative treatments" (2010, 51 cited in Deacon, 2013) and may herald the day when "the distinction between neurological and psychiatric disorders will vanish, leading to a combined discipline of clinical neuroscience" (Insel, 2007, 757 cited in Deacon, 2013). This optimism was largely affected by advances in medical science that presumptuously poised itself to "transform assessment, prevention, and treatment, and even eradicate mental disorders altogether" (Wolfe, 2012 cited in Deacon, 2013, 847). As already indicated, the biological perspective basically traces the cause of mental disorders to brain anomalies and rests itself on the claim that the same can be treated through medical treatment, therefore, research on mental disorder within medical science sought to develop somatic therapies that professed to offer curative treatment for biological dysfunctions. Deacon quotes Engel's critique which tersely summarizes the basic assumptions of the biological perspective,

> The dominant model of disease today is biomedical, with molecular biology its basic scientific discipline. It assumes diseases to be fully accounted for by deviations from the norm of measurable biological (somatic) variables. It leaves no room within its framework for the social, psychological, and behavioral dimensions of illness. The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioral

> aberrations be explained on the basis of disordered somatic (biochemical or neurophysiological) processes. (1977, 130)

Schwartz and Concoran (2010) once again draw our attention to the enthusiasm surrounding the biological perspective particularly in the 1990s, an era that was declared as the 'The Decade of the Brain'. A swelling wave of optimism surged through the aeon, projecting the success of medications in treatment of mental disorders. "This revolution was sparked by two achievements in biological psychiatry – the compelling evidence from twin and adoption studies for a genetic component to psychiatric disorders and pharmaceutical advancements in the development of drugs that target specific symptom constellations" (Chua and McKenna, 1995 cited in Schwartz and Concoran, 2010, 65). Developments in medical science that explained disorders such as Huntington and Alzheimer in terms of biological mechanisms substantiated this perspective and added to its credibility. In this context, Schwartz and Concoran quote from Andreasen to reflect upon the fact that the biological perspective on mental health had gained currency by indicating at human biological system, particularly the brain, as the source of all mental disorders; in the process negating the pertinence of the psychological and the sociological perspectives on the matter.

> It is a revolution not so much in terms of what we know as in how we perceive what we know. This shift in perception suggests that we need not look to theoretical constructs of the "mind" or to influences from the external environment in order to understand how people feel, why they behave as they do, or what becomes disturbed when people develop mental illnesses. Instead, we can look directly to the brain and try to understand both normal behavior and mental illness in terms of how the brain works and how the brain breaks down. The new mode of perception has created the exciting feeling that we can understand the causes of mental illness in terms of basic biological mechanisms. (Andreasen, 1984, 138 cited in Schwartz and Concoran, 2010)

The biological perspective on mental health was stoked up by the discovery that general paresis was caused by bacterial micro-organism which could be cured with penicillin, a discovery that led to the conviction that biological curative interventions could be applied to mental disorders as well. The adoption of electroconvulsive therapy (ECT), lobotomy, and insulin coma therapy in the 1930s and 1940s followed close at its heels by the discovery of compounds (in 1950) that reduced the symptoms of disorders such as psychosis, depression, mania, anxiety, and hyperactivity including the chemical imbalance theory that emphasized on the efficacy of medicines in the treatment of mental disorders heralded the decade that witnessed the surge of psychopharmacological revolution (Deacon, 2013).

Addlakha (2008) throws light on the fact that the upsurge of the biological perspective was much influenced by the arrival of the era of Enlightenment which hailed reason and truth above philosophical musings. Prior to the dawn of Enlightenment, medical theory was largely influenced by magic, astrology and religion which viewed man as a physical cum metaphysical being, a view that was replaced by science which, on the other hand viewed human body in terms of a machine. The biological perspective was largely inspired by the concept of mind-body dualism, suggested by French philosopher Rene Descartes, following the tenets of which this perspective considered the mental and the physical as dichotomous entities. Thus the biological perspective reflected on mental disorder as a disease, whose cure was possible through medical interventions. Moreover, the biological perspective was considered epistemologically superior for its reliance on science and therefore more credible.

Castillo (1997) has traced the progressive influence of the biological perspective on *Diagnostic and Statistical Manual on Mental Disorders*. He explains that while DSM –I exhibited an acclivity for the bio-psychosocial perspectives (which reflected upon mental disorder as a reaction to biological, psychological and social factors); DSM - II showed a shift towards the biological formulation on mental health, facilitated by the

introduction of lithium and neuroleptic medications in the 1950s and 1960s. DSM –III had taken a step further and adopted the disease centered model and by the 1980s the biological perspective came to hold its sway over mental health discourse. The resultant disease centered model allowed no scope of explaining mental disorder with reference to either psychological trauma or environmental factors.

The crux of the biological perspective is that disruptions and dysfunctions of the brain cause mental disorders. According to Schwatrz and Concoran (2010) the construct of interest here are the underlying causes of mental disorders, which are explained in terms of biological mechanisms (i.e., pathophysiology) and distinct causes (i.e., pathogenesis). Neuroscience constitutes the essence of this perspective which suggests that neurons condition human thoughts and behaviours (Cowan et al., 2000 cited in Schwatrz and Concoran, 2010) and therefore account for mental disorders. The biological formulations on mental health had projected much optimism in unraveling the causes of mental disorders and suggesting curative measures thereof. Despite this projected optimism, neuroscience alone has failed to account for mental disorders, their cause and treatment in totality. In spite of the advance of technology in terms of brain imaging techniques and molecular genetic testing, researchers have not yet discovered a single biological marker with sufficient sensitivity and specificity to credibly inform the diagnosis of any single mental disorder (Deacon, 2013).

Further, whether mental disorders qualify as diseases at all has been called to question by many (Szaz, 2001; Insel, 2010; Hyman, 2010 cited in Deacon 2013) who also caution us against acknowledging the DSM diagnoses as natural or given rather, as suggested by them, the same is to be viewed as heuristics. To draw a parallel between mental disorder and other physical disorders is considered presumptuous, because the suggestion of an underlying biological correlate for every kind of mental disorder has not yet been proven by medical science. In this context Deacon articulates that “Given the limitations of existing knowledge about the biological basis of mental disorder, declarations that mental disorders are “brain diseases” (Volkow, n.d.), “broken brains”

(Andreasen, 1985), or "neurobiological disorders" (CHADD, 2012) are perhaps best understood as the product of ideological, economic, or other non-scientific motives" (2013, 852). The biological perspective had exercised its hegemony for long but yielded little benefit to those suffering from mental disorders; the audacious claims made by the same had proven premature and much of its optimism misplaced. Though this perspective has ubiquitously indicated at biology, particularly brain diseases as the basis of all mental disorders, researchers have not been able to identify a single biological cause of any major mental disorder, and it is unlikely that any such cause would ever be discovered (Kendler, 2005 cited in Deacon, 2013). The etiological complexity of mental disorder is such that a uni-dimensional explanation of the same is implausible, rather all three aspects of the biopsychosocial model should work in tandem in broaching the subject of mental health.

The main allegation against the biological perspective is its reductionist approach which subsumes the relevance of psychological and social causal factors in holistically approaching mental health. The main tenet of this argument may be gauged from the articulation of former American Psychiatric Association (APA) president Paul Applebaum, who reflected that our brains are essentially biological organs and that every disorder, including mental disorder is the result of a biological process (Davis, 2003 cited in Deacon, 2013). Thus, the biological perspective has been projected by its proponents as fundamental in understanding and addressing mental disorders and bio-medical intervention as a panacea that would in time replace psychology with neuroscience and molecular biology (Gold, 2009 cited in Deacon, 2013). The focus only on the biological cause, however, is rather limitative as it fails to take cognizance of myriad other factors that lend their influences in shaping mental health. The asserted emphasis that all mental disorders are rooted in biological processes has not been scientifically validated. In spite of the revolution predicated by the biological perspective, the same has failed to prove with certainty that all mental disorders can be reduced to biology alone. This approach has received much criticism for its reductive claim and to overcome the limitation of the present model scholars like Engels have

offered a more holistic approach by suggesting the bio-psychosocial model, which allow the interplay of multiple perspectives in providing an explanatory model for the complex phenomena of mental disorder. Far from making sweeping generalization on mental disorders, the bio-psychosocial model "prizes multidisciplinary attempts to stitch together different levels of analysis by establishing principles that elaborate how processes at one level affect those at another (Caspi et al., 2003 cited in Deacon, 2013). The bio-psychosocial approach promotes dialog and collaboration across theoretically and technically diverse healthcare professions" (Deacon, 2013, 856).

1.2.2 Psychological Perspective on Mental Health

The enthusiastic anticipation (Deacon, 2013) surrounding the biological perspective has however, been challenged by the psychological perspective on mental health which voiced its dissent against the reductionism attempted by the proponents of the former, by unequivocally rejecting the psychological, behavioural and social factors that they argued ought to be factored in any mental health formulation. In contrast to the argument forwarded by the biological perspective, the psychological perspective predicates an alternative approach that focuses on "associative networks, based in the neural substrate, but developed through learning and relying on theories of conditioning, perception, appraisal and belief-formation, propositional and implicational encoding, mental models of the world, internalised schemas of relationships etc." (Kinderman, 2005, 209).The argument mooted in this perspective is that the core element of individual personality development is pinned on its ability to adjust to the external environment. To the advocates of this school of thought, dysfunction occurs when along the trajectory of development an individual fails at appropriating the ability to adjust or develops mal-adaptive practices in response and reaction to the external circumstances.

Building on the psychological perspective on mental health, Christopher Peterson (2010) outlines four psychological models to explain mental disorder or 'abnormality'

viz. the psychoanalytic, cognitive – behavioural, humanistic-existential-phenomenological, and the family systems models.

A. The Psychoanalytic Model

The psychoanalytic model is based on the theory of Sigmund Freud. This model hinges on the developmental approach and attempts to explain personality disorders in terms of events and occurrences experienced early on in life. The implication here is that behavior structures that a child develops in early stages of life shape their adult personalities.

> Freud believed that children develop by passing through a fixed sequence of psychosexual stages – discrete periods defined by the part of the body that provides gratification of the sexual drive. The child who passes through these stages – oral, anal, phallic, latency, and genital – in satisfactory fashion becomes a normal adult. But frustration or indulgence at any stage may leave the child with a fixation at that stage that influences adult character. (Peterson, 2010, 91-92)

Further Freud suggests that human beings are energy systems, the psychological energy (that Freud terms as drives) are abundantly present in children. Through the process of socialisation the children are educated on controlling these drives and regulating the unbridled energy, however, socialisation is never completely achieved and hence produces "casualties: both people who never learn to control their drives and those who control them too well" (Peterson, 2010, 92). Thus, explaining how abnormalities or aberrations occur in personalities. A significant aspect of this model is how it explains mental structures. Freud posits that *id* is the only mental structure possessed by the infants– which accounts for the irrational and emotional aspect of their behavior. Through the process of socialisation, the infant develops *ego* which teaches it to regulate its behavior with respect to external constraints. Internalization of social norms and codes of conduct develops the third mental structure, which is the *super ego*.

The interaction of the three structures affects personality and also accounts for the problems therein (Peterson, 2010).

Freud's psychoanalytical model attempts to explain mental disorder in terms of defense mechanisms which are the unconscious strategies used by the *ego* to protect itself from external threats. In disordered personalities these defense mechanisms are either exaggerated or particularly immature, as Peterson suggests

> Defenses can end up being problems in their own right. Consider multiple personality disorder, the existence within the same individual of discrete personalities with little awareness of one another. Research implicates sexual or physical abuse in the childhood of most people with this disorder (Putnam, Guroff, Silberman, Barban and Post, 1986 cited in Peterson, 2010). One interpretation is that individuals who later develop multiple personality disorder create in childhood an alternative personality as a defense against abuse. It is a way to escape an intolerable situation, psychologically if not physically. This strategy, although useful at the time, creates obvious problems for those who continue to use it. (2010, 93)

B. The Cognitive-Behavioral Model

This model suggests that behavior of an individual develops as a response to the external environment. Bandura (1986 cited in Peterson 2010) terms this interaction as *reciprocal determinism.* Cognitive - behavioral theorists posit some learning processes that shape human behavior *viz*.

I. Classical conditioning, which shapes emotional reactions in response to previously neutral external stimuli, for instance individuals who have had a series of traumatic experiences with a particular relation or object may well develop an aversion for the same.

II. Operant conditioning, which shapes behavioural responses with respect to the consequence the same generate. If the consequence is reinforcing then the response is repeated while if the response results in negative consequence the same is avoided.

III. Modeling or vicarious conditioning in which behavior is learnt by watching others. If the model meets with a reward, then his or her example is more likely to be followed even in problematic directions (Peterson, 2010).

The behavior that an individual projects as a reaction to the external environment is however transacted cognitively, that is to say that the behavioural reaction is influenced by how the individual interprets the events, and thus the reality that shapes human behavior is actually a perceived reality. In this regard, mental disorder is thought to be brought about by such unusual experiences or ways of thinking. "For example, schizophrenic individuals have difficulties in the psychological mechanisms responsible for selective attention. Too much information is available to them, and they think in overtly inclusive terms. The hallucinations and delusions that characterize schizophrenia are derived from these attentional problems" (Peterson, 2010, 97).

C. Humanistic-Existential-Phenomenological Model

Humanists, notably Abraham Maslow and Carl Rogers argue that individuals strive to realize their potential through a process they term as self-actualization. Several conditions may constrain this process of self-actualization; however, if a change is brought about in the constraining circumstances an individual may wholly realize her/his potential. The humanistic model often interacts with the existentialist approach which extols subjective experience over everything else. The existentialists refute universal, generalized human nature and conceive each individual as a unique persona shaped by one's personal choices and how one defines oneself. The humanists and the existentialists align themselves with the phenomenologists who emphasize that the experience of a person is meaningful for the same and that an individual's experience ought to be appreciated from the perspective of that individual alone. The common

element in all the three strains is the emphasis on subjective experience of individuals, which is oft ignored by traditional psychiatrists and psychologists. It may be pertinent at this point to draw from Liang (1959 cited in Peterson, 2010) who invites attention to the personal experience of the mentally disordered, which defines them as our own experience defines us. According to the humanistic- existential-phenomenological model, the problem with the mentally disordered lies in the discrepancy between how they perceive themselves and how the rest of the world views them, put in other words what is understood as mental disorder is actually a deflection occurring in the path of self-actualization or a halt in psychological growth.

D. Family Systems Model

This model posits that personality disorders of individuals occur owing to the problems or discord that exist in their immediate social context, that is, their family. Thus, mental disorders such as depression, anxiety, and substance abuse are manifestations of disturbances occurring within the family (Jacobson and Addis, 1993 cited in Peterson, 2010). The behaviour and interaction pattern of each family is unique and the behavior of each family member is shaped as a cause and effect of other members' behavior. To explain mental disorder the present model,

> …focuses on the factors existing among family members that maintain the behavioral status quo. The status quo is called *homeostasis*: balance among the behaviors of the family members. Conflicts in one aspect of the system are counteracted by changes elsewhere in an attempt to restore homeostasis. In a healthy family, the status quo is one in which the individuals can thrive both as individuals and as family members. But in other families, the status quo is achieved at a cost. An individual might develop "symptoms" as a way of compensating for problems elsewhere in the family. (Peterson 2010, 103)

What is suggested by the model is that individuals with mental disorder are the ones who have been affected the most by their family problems. This model is, nonetheless, ridden with flaws as it squarely levels blame on family problems for mental disorder that a family member may suffer from and remains rather myopic to other causal factors.

Psychological disorders, as envisaged by this approach refer to the consequences of "potentially life-shaping experiences, or circumstances, that affect mental health — childhood sexual abuse, bullying, attachment relations with parents, assault, and all other major and minor interpersonal experiences. Although these circumstances are of disparate kinds, they and many other life events contribute to mental disorder" (Kinderman, 2005, 208). Psychological causes of mental disorders refer to the potentially damaging events that occur in the course of an individual's life. The term psychological also connotes the process of subjective interpretation or information processing whereby personal meaning is attached to events encountered by an individual in her/his life. This ascribed meaning is an individual's personal assessment of life events which may stand in contradiction to how the world at large views the same. Thus, whereas the biological perspective implicates abnormalities in the functioning of the brain, the psychological perspective hypothesizes that the causes of mental disorders are embedded in the unconscious realm of the mind which retains the impression made by past experiences, especially negative emotional experiences that may have occurred in the formatives stages of one's life. Psychological perspective on mental health offers an insight into a wider causal spectrum than just the anomalies of brain as envisaged in the biological perspective, by delving into the interactions and interrelationships between individuals and their life circumstances. An important point that merits attention here is the distinction that this model makes between the actual life events and the interpretation of the same, the latter, as suggested by the model is affected by psychological processes. Unlike the biological perspective, the psychological perspective takes cognizance of the biological, social and circumstantial factors; however, in explaining mental disorder the conjoint interaction of the outlined

factors on psychological processes is emphasized. An instance in point is depression which may be caused by genetic factors, biochemical imbalance, or negative circumstantial events. However, these myriad factors stand to affect the psychological mechanisms of an individual such as self-esteem, social cognition etc. and eventually cause mental disorder (Kinderman, 2005). Nonetheless, this emphatic claim of the psychologists that all mental disorders are to be traced to the dysfunctions of psychological processes which mediate the effects of biological and sociological factors remains challenged.

1.2.3. Sociological Perspective on Mental Health

To the canon of literature on mental health, the sociological perspective has added a significant dimension towards a more comprehensive understanding of mental health. Peggy Thoits points out that according to the sociological perspective, mental disorders commonly occur as a result of environmental factors rather than as consequences of physical anomalies (as projected by the biological perspective) or aberrations in the mind or psyche (as projected by the psychological perspective) . Whereas the latter perspectives locate the determinants of mental disorder within the human entity, the former locates it without, i.e. in the social environment one is situated in (2010). Though the biological perspective remained preponderant on the way mental disorder was conceptualized and addressed, it was pointed out by many scholars that social, economic and cultural aspects ought to be factored in as biological factors occur in conjunction with the socio-cultural reality of an individual's life rather than in isolation from the same (Addlakha, 2008). Addlakha refers to the works of Freud on psychoanalysis which took cognizance of childhood development, culture and sexuality in affecting mental health thereby opening up to perspectives from psychology, sociology and anthropology and questioning the arrogations inherent in the biological perspective in unfurling the intricacies of the subject.

In explaining the provenance of the sociological perspective it may be worthwhile to look at two popular sociological formulations on mental health, i.e. social construction

and social framing. One may fall back on the post-modern understanding of the body as a socially constructed reality rather than as a universal and natural entity, as is espoused by the biological perspective (ibid.). Here attention is drawn to the post-modernist claim that all notions surrounding the body, e.g. its normality or abnormality and its well-being or ill-being are churned and chiseled by socio-cultural values and are not necessarily objective realities. Relying on this frame of argument, post-modernist scholars make the vehement claim that mental disorder is a social construct. Here the suggestion is that the assumptions on mental disorder are not inevitably objective or scientific, rather socially controlled and managed. Culture attaches meanings and values to experiences of mental disorder, thus, conditioning the way the same is conceived and addressed, this rationale implies that mental disorder is socially constructed. From a postmodern perspective, the medical and psychological vocabularies of illness do not represent reality; rather construe a reality or perspective. The suggestion that mental disorder is a social construct may indicate that the same is a "product of how humans think about and act in the world - a proposition that is likely to be elaborated in terms of claims that what is so categorised, and the meanings attached to the categories, vary across time and place" (Busfield, 2010, 5). Importantly, however, this argument reduces mental disorder to a social category and denies it any objective reality. In this respect, the claim gives in to the same error of reductionism committed by the biological perspective by negating human experience attached to mental disorder. Though the perspective of social construction has contributed much in terms of elucidating the process whereby categories of mental disorder are shaped, the same suffers from certain limitations particularly in denying mental disorders any material reality. In this context, approaches such as that forwarded by Charles Rosenberg (1992 cited in Busfield, 2010) on social framing of mental disorder provides a more viable alternative. The concept of social framing of mental disorder attributes due weightage to social processes in shaping the concept and categories of mental disorder and at the same time does not subsume the objective reality of the same. The concept of social construction has irked many, whether doctors or patients, owing to its denial of the suffering involved in

mental disorders and therefore the concept of social framing has found wider acceptance because of its relatively broader vision.

According to the sociological perspective, the biological and the psychological stance lead to pathologisation of the individual. The advocates of the sociological perspective forward the opinion that biological and psychological characteristics of the human subjects are not the sole determinants of their mental health; structural features which determine role and status of members of a society, shape their behaviour and influence the logic of resource allocation, thereby privileging some members of the society to the detriment of others, call for as much attention, if not more. The thrust of the argument is that genetic and psychological factors on their own cannot account for mental disorder; cognizance has to be taken of social dynamics in explaining mental health and disorder. As Busfield articulates,

> Geneticists' reported claims notwithstanding, social processes are crucial to the understanding of mental health and disorder in a range of ways. First, social processes shape the very concepts of mental health and disorder, thereby setting the boundaries of what constitutes mental disorder and the categories that are used to distinguish one disorder from another. Second, social processes play an important part in the aetiology of mental disorders - any mental disorder is always a product of genetics and environment (Rutter and Plomin 1997 as cited in Busfield, 2000). And third, social processes play a vital part in influencing mental health practice. (2000, 2)

Several early thinkers of the domain have reflected on how mental disorder is not simply a biological phenomenon, and have thrown into relief the social influences on the same. Early sociological musings on mental health and disorder can be traced to Emile Durkheim who explained social conceptualization of the normal and the pathological to reflect on how anything that resides outside of the pale of socially acceptable behaviour is denigrated as pathological. Durkheim opined that acceptability

of behavior is guided by the prevalent norms of a particular time and place; such norms are, however, variable and subject to change and are enforced with the intent to maintaining social cohesion. Thus, borrowing from Durkheim mental disorder may be understood as a state that does not conform to the socially contrived concept of order or normalcy. In a similar vein, American sociologist Talcott Parsons posited the idea that disorder of any kind (including health disorders, mental or physical) may be viewed as deviance as the same poses itself as a threat to social order. Thomas J. Scheff took a radical stand in positing how deviance from socially prescribed norms of behaviour comes to be labeled as mental disorders. Anti-psychiatrist, Thomas Szasz reflected on how violation of social, political and ethical norms is misconstrued as mental disorder (Busfield 2000). These references are indicative of the fact that social factors determine the manner in which mental disorder is perceived and addressed and impels one to think beyond biological and psychological formulations in approaching the larger issue of mental health.

Further, Busfield (2000) points at some sociological studies that have fore-grounded the sociological perspective on mental health. Prominently, the social ecological study conducted by Robert Faris and Warren Dunham (1939 cited in Busfield, 2000), where the duo argued that schizophrenia cannot be explained in terms of genetics alone but also with respect to the social setting of an individual, as they had observed notably high incidence of the same in areas with low community network and high social isolation. Further, American study, *Social Class and Mental Illness* (1958 cited in Busfield, 2000) by A.B. Hollingshead, a sociologist, and F.C. Redlich, a psychiatrist related mental disorders, especially psychosis, with social class. Another study held up in this regard by Busfield is that of George Brown and Tirril Harris's (1978 cited in Busfield, 2000) well-known British community survey, *Social Origins of Depression*, which indicated at the stressful events and inimical circumstances in the life of individuals which make them vulnerable to mental disorders. It may be worthwhile to refer to yet another significant study, that of Gove and Tudor (1973 cited in Busfield, 2000), which attempted to explain gender differences in mental health by indicating at

marital roles as stressors which account for a greater vulnerability of women to mental disorders. This aspect shall be dealt in greater detail subsequently in the course of the thesis. Further, many a sociological work, especially those with an acclivity for symbolic interactionism has brought to light the role of interpersonal dynamics in affecting mental health. Notably that of Edwin Lemert's (1962 cited in Busfield, 2000) *Paranoia and the Dynamics of Exclusion*, in which the author has deliberated on the complex social processes that contribute to the development of paranoia. The purpose and intent of these studies, however, have been to direct attention to social factors that play a significant role in affecting mental health (Busfield, 2000).

To trace the growth of the sociological perspective on mental health, it may also be pertinent to draw in the reference of Foucault (1961cited in Addlakha, 2008) who conceptualized madness as an antipode of reason. He refuted any claim of the same as a scientific concept rather emphasized that madness is a notion shaped by Enlightenment. Foucault had directly called into question the credibility of the biological and the psychological perspectives by conceptualizing madness in terms of unreason or irrationality. Foucault lent yet another dimension to this domain by indicating how scientific knowledge becomes an instrument of power in controlling the human body. "He employs the term biopower to highlight the social and individual control of the body through discourse embodied in the scientific disciplines of penology, psychiatry, and clinical medicine" (Addlakha, 2008, 13). Foucault's theory has definitely lent itself as one of the stanchions around which the sociological perspective builds itself.

It may be worthwhile to note the important aspects to which the sociological perspective invites attention. For instance, this perspective harps on the role of community to which an individual belongs, the historical period in which she/he is located and the cultural values to which she/he subscribes in affecting the cause and consequence of the individual's mental disorder. That is to say that life events, social conditions, social roles, social structures, and cultural systems of meaning are factors that need to be acknowledged in understanding the influences on mental health. Further,

social characteristics such as gender, ethnicity, age, and education have been identified by this perspective as determinants of mental health. Culture which refers to the system of shared values and beliefs also exercises its influence on mental health not only in explaining how the same may be caused but also how it shapes social responses to mental disorder. Horwitz (2010) has indicated at a few social factors that exercise considerable influence in shaping mental health, some of them have been discussed below:

A. Social Integration

Here Horwitz (2010) draws from Durkheim who explained suicide as a social phenomenon, and that individuals sharing strong bonds with other members of their society as well as with social institutions (such as religious institutions, civic organizations and clubs) are least likely to commit suicide. In the same vein, Horwitz suggests that societies that have strong systems of social integration contributed to optimal mental health of their members. Social situations marked by disharmony, lack of attachment and incoherence foster mental disorder among its members. "Social integration is associated with positive mental health – humans derive satisfaction from valued intimate relationships and suffer when their circumstances deprive them of these relationships" (Horwitz, 2010, 11).

B. Social Stratification

Stratified societies with uneven distribution of power, resources and status prove pernicious to the mental health of the members residing therein. Those who enjoy the privileges of power, wealth and status reflect a more positive mental health than those that live in deprivation of the same.

C. Inequality

Horwitz draws attention to inequalities in wealth, power, knowledge, influence, and prestige, in other words inequality in social class which exercises substantial

influence on mental health. “Poverty involves not only economic deprivation but also undesirable working conditions, physically hazardous environments, marital instability, and unhealthy lifestyles, is especially associated with poor mental health” (McLeod and Nonnemaker, 1999 cited in Horwitz, 2010, 11). Mental disorder is observed more among those who live in deprivation than those who enjoy the privileges of life. However, this position of privilege, according to Horwitz, is a relative assessment and should not be understood in absolute terms. In this sense, even the wealthy and resourceful may be mentally disturbed if they perceive a relative inferiority in their status by comparison with those better placed than them. A point that merits attention here is that inequality is not to be interpreted in terms of economic resources alone, rather inequality may be experienced in the professional arena (particularly when one has to perform jobs that lack autonomy) as well as in marital relationships (when one spouse exercises domination over the other). In both the cases, the impact on mental health is inconvertibly negative.

D. Cultural Values

Cultural values of a society that promote cohesion among its members, set realistic and attainable goals and conduce an environment of mutual support nurture positive mental health, while those that foster competition, individualism and extol material accomplishments have proven to be stressful for individual members of the society. Religion is an important aspect in this respect that plays a substantial role in influencing mental health. Horwitz (2010) suggests that religious individuals experience less distress as reliance on god and religious values act as a buffer in the teeth of adversities. However, it would be erroneous to assume that religion invariably promotes mental health; religion can also act as a stressor, a dimension that will be explored later in the course of this work.

E. Cohort Membership

Horwitz (2010) also makes a mention of birth cohorts to elucidate the influence of social factors on mental health. "A *birth cohort* is a group of people born in a particular time and place; for example, all Americans who were born in the decade of the 1980s. Each cohort shares common historical and social experiences that are different from the experiences of other cohorts" (Horwitz, 2010, 13). The unique experience of a people belonging to a particular cohort, whether historical, political, economic or environmental lends a credible influence on their mental health. To aver from this logic, mental disorders are not just individual characteristics but also reflective of the dynamics of the era in which one happens to be born. The structural features of a particular era contribute to the trials and travails of the generation living around the time and leave a distinctive impression on their mental health. As Horwitz (2010) holds up, unfulfilled aspirations in the face of global economic scenario poses the greatest threat to the mental health of the young generation of today.

F. Cross-Cultural Differences

The rate of mental disorders across time and space is variable which implicates that stressors such those discussed above vary across societies. Some societies reflect greater stringency in terms of the delineated factors whereas other societies offer a more egalitarian structure. While the former poses as inimical to mental health, the latter may actually contribute to positive mental health. Thus, it becomes evident that social factors cannot be shoved out of the ambit of discussion particularly when it concerns mental health and disorder. Drawing from this argument one may reiterate that mental disorder is to quite an extent influenced by social contexts which is reflected in the variability of its prevalence and symptomatology (though some forms of disorder remain universal). This calls to question the claims of medical etiology that emphatically asserts irregularities in the biological, neurological, biochemical or genetic system as source of all mental disorders. Had the latter argument been inconvertible, then all forms of

mental disorder should have remained culturally invariable which, however, is far from being true (Scheid and Brown, 2010).

The sociological perspective on mental health has been skeptical of the DSM categorization of mental disorders as the same is reflective of rather myopic psychiatric conceptualizations stemming out of clinical observations, oblivious of other parameters such as the social context. It has been asserted that "the absence of gold standards, the paucity and uncertain relevance of latent biological classes, and the symptom factors that bear little resemblance to diagnostic 'syndromes' lead us to believe that psychiatric diagnoses, whether simulated or clinical, are mythical entities" (Mirowsky and Ross,1989, 17 cited in Scheid and Brown, 2010, 4). Sociological critique of the biological perspective is essential as it is an attempt at thwarting the spate of biological reductionism, biological determinism, and the hegemony of biological explanations for mental disorders. The sociological perspective opens up the vista of discussion by including perspectives from the social domain, by questioning the medicalization of social phenomena and the presumption that all mental disorders, like that of physical disorders, have an organic genesis.

The contribution of the sociological perspective in understanding the cause, course and consequence of mental disorders is indeed credible; however, the same stands the risk of being over-ridden by the progress made in the domain of bio-genetics. Research conducted in the domain of natural sciences gains precedence in comparison to research in social sciences. Theoretical as well as empirical bases of social science research on mental disorder have been called to question by those who favour the sound empirical grounding of scientific research. Moreover, the sociological perspective has been slighted by many as a recent commentator on mental health and disorder that rose in response and reaction to the dominant discourses on mental health that is, the biological and psychological discourses. However, scholars of the domain claim that social science predates medicine, "before the latter settled down to become preoccupied with individual bodies and their parts, social medicine emerged in the eighteenth century as a

programme of political intervention to prevent ill health" (Rosen, 1979 cited in Rogers and Pilgrim, 2005, 21). Moreover, several epidemiological work of consequence were produced in the initial years by psychiatrists in collaboration with sociologists, till the anti- psychiatry movement of the 1970s. There is no denying the fact, however, that the sociological perspective has broadened the expanse of understanding mental health and illness by drawing attention to the social factors influencing aetiology and offering competing ways of conceptualizing mental disorder.

To summarize the crux of the sociological discourse on mental health, one may refer to the following theoretical perspectives suggested by Rogers and Pilgrim (2005).

A. Social Causation

This perspective draws attention to stress caused by social factors which may prove disadvantageous to an individual, such as poverty, age, sex and race. The core enterprise here is to establish a veritable link between mental disorder and social factors, particularly those factors that prove inimical to individuals.

B. Critical Theory

This perspective focuses on the socio-economic structures and their influence on unconscious mental life. The principal advocates of this perspective were the scholars of the Frankfurt School, whose engaging concern lay in connecting the triple strain of economy, culture and psychopathology. It offers an important point of consideration to the present discourse by suggesting a link between psyche and society.

C. Social Constructivism

The central assumption here is that "reality is not self-evident, stable and waiting to be discovered, but instead it is a product of human activity" (Rogers and Pilgrim 2005, 15). This perspective forwards the rationale that what is claimed as scientific

knowledge of health and disorder is actually constructed, in which the power machineries active in a particular social situation have a role to play. Knowledge that regulates the boundary between health and disorder, normal and abnormal is actually a mechanism of control wielded by the powerful. Thus, the reality of mental disorder itself is questioned by this perspective; thereby suggesting that social forces, more often than not, construct the notion of illness and that the same has little to do with reality or the actual state of affairs.

D. Social Realism

This perspective stands in contradiction to what the previous one suggests. Here the emphasis is that "human action is neither mechanically determined by social reality nor does intentionality (voluntary human action) simply construct social reality. Instead, society exists prior to the lives of agents but they become agents who reproduce or transform that society" (Rogers and Pilgrim 2005, 18). In this sense, material reality does influence action but does not determine it entirely. It averts the extreme reductionist stance posited by social constructivism which denies mental disorder any reality. Social realism, on the other hand posits that mental disorder is a natural category which nonetheless reflects variability in terms of time and space, thereby acknowledging the social influence on the same. It is important to note that social realism does not bring into question whether reality is socially constructed or not, rather it expressly suggests that the theories of reality are shaped by social forces and interests such as gender, class, race and culturally promoted ideals. Here the claim made is that all work on mental health is influenced by social structures, therefore, any objective work on the same, as may have been yielded by natural science explorations, is untenable. Though this perspective reflects its acclivity for scientific research it does not succumb to the reductive realism promoted by the biological perspective, rather it accords due weightage to the influences of social factors and interests in construing the reality of mental disorder.

In the present exploration, centre stage has been occupied by the sociological perspective, drawing from which, some aspects of socio-cultural life that have a bearing upon the mental health of women will be subsequently explored. The principal intent here is to deliberate on the debilitating effect that negative social factors have on mental health particularly, women's mental health owing to the historical socio-cultural disadvantages the latter is subjected to. Factors such as stress generated by the socially induced subjugation, oppressions of social institutions such as religion and marriage, economic disadvantages (to name a few) take their toll on the physical and mental health of women. The same therefore, warrants that the domain of mental health should take within its ambit of consideration social causative factors in addition to those put forward by medical sciences in adequately addressing the issue.

The bulk of the present study has highlighted the impact of socio-cultural factors on mental health; however this study does not stand to deny credence to the other perspectives on mental health, *viz.* the psychological and the biological perspective. Rather, it is suggested that the three perspectives should work in tandem to address the domain of mental health. In this regard the bio-psychosocial perspective is vouched for. Contemporary approach to mental health favours the bio-psychosocial perspective. The tenets proposed by this perspective have gained the favour of many scholars as they consider the same to be more scientific, pragmatic and above all more humanistic. This model as conceived by Engels integrates the biological, psychological, and social factors in conceptualizing mental health and also in designing a care module for the same. In this context we may recall the words of Ghaemi, "no single illness, patient or condition can be reduced to any one aspect (biological, psychological or social). They are all, more or less equally, relevant, in all cases, at all times" (2009, 3).

1.2.4 Bio-psychosocial Perspective on Mental Health

The complex domain of mental health is but inadequately addressed by any one of the perspectives outlined above, as each of them focuses on one or the other aspect in attempting to explain the cause, consequence and redressal mechanism of the same.

However, a pluralistic explanatory mechanism may serve better in this regard as it brings within purview multiple aspects of concern which help understand mental health better. A synergy of perspectives from the three formulations on mental health, i.e. the biological, the psychological and the sociological would provide a holistic understanding of the same as opposed to the reductive stand that each posits in its own right. In this respect, the bio-psychosocial perspective is a multidisciplinary approach that vouches for an integration of multiple strands of thought drawn from the three variegated perspectives discussed above. It acknowledges the interplay of the three aspects, i.e. the biological, the psychological and the sociological in affecting mental disorder. Engel is credited with the conceptualization of the bio-psychosocial model. Engel shaped his approach in line with the general systems theory in biology, where the rationale is to bring about a conjunction of myriad perspectives in addressing complex issues (Ghaemi, 2009). His stand was a reaction against the narrow approach of the biological perspective, which though had made credible contribution in the advancement of medical science, nonetheless, objectified the patients, leaving little room for subjective experience that ought to be factored in scientific studies on mental disorder. Engels model had taken a strong stand against the mind- body dualism and the overt insistence on bodily dysfunctions forwarded by the biological perspective as emotions and feelings bear as much weightage as do bodily anomalies in affecting mental disorder. The excessive reliance on scientific mechanisms in detection and cure of mental disorder which stands to negate the human dimension inherent in the same was also rejected by Engel. He was of the opinion that a purely objective exploration of mental disorder remains incomplete without adequate focus on the human dimension of both the patient as well as the physician. This model, therefore, struck a chord with those within the medical profession, and without, keen on giving medical practice a more human face. (Borell-Carrio, 2004)

Engel attempted to view an individual with mental disorder or for that matter any other kind of disorder, as a part of the whole system, rather than an isolated entity. The system is itself endowed with sub-personal (organic) and supra personal (psychosocial)

elements. These elements are integrated and interdependent features of the whole system. Therefore, considering only the sub-personal factors, as has been the mainstay of the biological perspective, would essentially be reductive and against the rationale for holism (Pilgrim 2002). The model as propounded by Engel is not so much a paradigm shift triggered by the failings of the dominant biological perspective; rather it is an attempt to broaden the spectrum of consideration in addressing the diagnosis and cure of mental disorder. The intent of the bio-psychosocial perspective is to affect a change in the clinician's gaze in a way as to ensure its maturation from objective, detached observation to a participative, reflective engagement. This appeal of the bio-psychosocial perspective has sustained itself through decades till the present times (Borell-Carrio, 2004). It has offered a riposte to the dehumanizing, presumptuous and reductive stand of the domineering discourse of the time, inspired by bio-medical inventions and has paved the path for a holistic understanding of the issue, borrowing ideas from the realms of biology, psychology and sociology. Though the present reconnaissance is focused on the sociological perspective, nonetheless, there is an expressed acknowledgement that the subject of mental health should be approached in a holistic manner weaving all strands of consideration in order to arrive at a mature and wholesome understanding of the same.

1.3 Rationale of the Research

The present research aims at exploring mental health of women from the sociological perspective. The core contention here is that mental health can be potentially threatened by factors other than the biological and psychological. Social factors certainly exert a nocuous effect on mental health of women, and, undermining the role of the same would tantamount to delegitimatzation of women's experience and their voice (Davar, 1999). Women's mental health is relatively more threatened by their complex social circumstances, a factor that is oft passed over by the biological and psychological perspectives. Alienation, powerlessness, and poverty experienced by women negatively impacts their mental health and may culminate in neuroses such as

depression, anxiety, obsessive compulsive disorders, somatic symptoms etc., commonly observed among women (Addlakha, 2008). Therefore it is important that mental health be approached from a gendered approach which offers a sensitive understanding of how gender inequality affects mental health (Afifi, 2007). Gender blind deliberations on mental health of women have indicated that women's biological disposition make them particularly vulnerable to mental disorders. This assumption has held its sway over mental health discourse for long with the consequence that women were considered as having an inherent propensity for mental disorders particularly owing to their biological and hormonal configurations (Showalter, 1987). Further, owing to this over insistence on women's biology the focus on social determinants of women's mental health had largely petered out of research agenda. Academic and institutional practices turned a blind eye on the social aetiology of mental disorder, thus, making redundant women's subjective experience and their perspectives. Since the 1990s, however, deliberations on mental health have reflected upon the positive correlation between social factors such as poverty, environmental stressors, unfavourable life events, lack of autonomy and agency, absence of supportive social network, exposure to violence and women's mental health (Astbury, 1999). It may be pertinent to recall Joan Busfield who clarified that "… different structural and material circumstances of men and women and the differences in power and status are highly pertinent to understanding the genesis of men's and women's mental disorder (as defined in specific times and places)" (1996, 236). The differential status accorded to women by gender biased society exposes them to certain hazards which stand to affect their mental health in a negative manner. This trajectory of thought, hence, calls for exploration of women's mental health from the sociological perspective in order that the connection between structural factors and women's mental health may be delved into.

The present study focuses on the vulnerabilities women are exposed to in the course of everyday social interaction and how the conglomerate of distressful events affects their mental health. In India the male dominated structural organization is particularly unpropitious for the females; therefore the same offers a rife context for the study. An

array of issues affecting women for instance religious regulation, marriage, economic deprivation, violence etc. have been studied in relation to women's mental health. Social reaction against women suffering from mental disorders has also been integrated into the ambit of the study. Furthermore, cultural influences on the manner in which mental distress is articulated by women has been explored to gauge the imprint of the former on human psyche and persona. The over-arching intent here is to link the tripartite i.e. women, socio-cultural factors that shape their lives and the imprint of the same on their mental health.

The present research dwells upon the effect of structural factors on the overall mental health of women and consciously avoids the realm of severe mental disorders. The spectrum of severe mental disorders includes serious conditions such as schizophrenia, manic depression, bipolar etc. and is thought to have a bio-genetic underpinning (Addlakha, 2008). The argument here is that socio-cultural factors cause common mental disorders or neuroses among women. At this point it may be worthwhile to note that the term mental disorder has been used, hereafter in the study, to indicate at the array of common mental disorders afflicting women such as depression, anxiety disorder, personality disorders as the same are enrooted in the life circumstances of the women.

1.4 Research Methods

1.4.1 Objectives of the Study

A. To study mental health of women from sociological perspective in order to understand how the web of socio-cultural forces spun around the lives of women affect their mental health
B. To explore how distress caused by structural factors affects mental health of women
C. To explore how exposure to inimical social circumstances such as violence pose as stressors and impact mental health of women

D. To study the social repercussions faced by women suffering from mental disorders
E. To study dissociate behaviour as culturally conditioned expression of mental distress experienced by women

1.4.2 Universe of the Study

The study has been conducted in the state of Assam, one of the seven states of North East India. According to the 2011 census the population of Assam stands at 31 million (with male and female population of 15, 939, 443 and 15, 266,133 respectively). Spread over an area of 78,000 sq. km, it is the 16th largest state of the country. Assam has 33 districts, 78 subdivisions and 219 community development blocks. Multi-ethnic, multi-linguistic and multi-religious, the state of Assam has been selected owing to the diverse social context it offers, which has enabled the researcher to study the socio-cultural life of people in its variegated dimension.

For the purpose of the study, nine districts of the state have been randomly selected *viz*. *Sonitpur, Darrang, Dibrugarh, Jorhat, Golaghat, Bongaigaon, Tinsukia, Cachar, Kamrup.* The data for quantitative analysis has been collected from the above mentioned districts.

However, the cases for qualitative analysis have been largely drawn from the district of Sonitpur. Selection of this locale was conscious owing to the location of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health herein. Some of the cases studied have been identified from the outpatient department of the institute. Moreover the researcher is based at Tezpur (a town located in Sonitpur), therefore, it was convenient to access the cases within the locale.

1.4.3 Overview of Research Design

In order to realize the purported objectives, the study has adopted triangulation of quantitative and qualitative methods. The selection of triangulation as a method of research was a conscious decision as the same allowed for the study to be conducted from both quantitative as well as qualitative perspectives in order to achieve a holistic understanding of the researched subject and greater accuracy of result (Jick, 1979**).**

Quantitative method has been employed to analyze the opinion of people on the influence of social factors on mental health of women and the social reaction towards the mentally disordered. Quantitative method is particularly suited to analyzing huge data, therefore the same has been adopted to process the response of the people (on the issues mentioned above) collected on a fairly large scale (from 830 respondents). Nevertheless, this method is beset with its own challenges as it is rather ill-equipped to capture the subjective experience of the respondents.

The ontological foundation of the study rests on the idea that subjective realities of people are unique to them and shaped by their particular context and experience. As subjective entities, human beings live unique experiences which may be best analyzed employing qualitative method. Hence, the same has been used to analyze the response of the researched with the view to gaining an insight into the profundity of their experience and their narratives.

The study has been largely shaped by deductive reasoning, where the theory that social stressors bear a negative impact upon mental health, particularly that of women (Davar, 1999; Addlakha, 2008; Busfield, 1996) and that prevalent culture lends a decisive hand in shaping the psyche of individuals (Kakar, 1997; Castillo, 1997) manifested especially in dissociative behaviours prevalent among women have been tested in the field in order that evidence supporting the claim may be gathered.

While the above argument has been well established by several academic researches, the present study applies the same in the context of Assam. The social scape of Assam has offered the scope to study a range of social factors in their relation to women's mental health. Further the study conducted in the culturally diverse locale has enabled the researcher to explore a culturally variegated spectrum in order to study the imprint of cultural learning on human psyche and persona.

1.4.4 Sample Design

Quantitative method has been employed to study the social aetiology of mental disorder among women, and the social backlash on women suffering from mental disorders. For quantitative analysis a multi-stage sampling technique was developed for which the respondents have been selected from the selected nine (9) districts mentioned above. Two (2) blocks from each district have been randomly selected. Therefore eighteen (18) blocks have been selected for the study. From each block four to five (4-5) villages were, once again randomly, identified; thus, the sample respondents have been drawn from 88 villages.

Thereafter seven to ten (7-10) respondents were identified from each village for the sample. The selection of respondents was purposive, as the identification of households which had women suffering from common mental disorders was imperative. It was purported that using the key informant technique women with mental disorder would be located in the selected villages, who along with respondents from their neighbouring households would be interviewed. It was a prepended design to interview at least one woman with mental disorder (identified through key informants) in each village and 6-9 neighbourers (female) of the same. Thus, a total number of 830 respondents were considered for the survey.

SI.No	Description of Sample	
1.	District/Block/ Village	TOTAL
2.	Number of Districts	9
3.	Number of Blocks	18
4.	Number of Villages	88
5.	Number of Respondents	830
		(Of the total 830 respondents, 114 are married and unmarried women with common mental disorders. The rest being female respondents drawn from the social locale of the 114 women suffering from mental disorders)

Rationale for purposive selection of households lies in the conscious design to capture the voice and experience of women who suffer from mental disorders and that of the people with whom they have close social interaction that is the people inhabiting their vicinity. The latter was included to understand opinion, attitude and response of the people particularly towards the mentally disordered women. An overview of the sample is reflected in Table 1a and b provided overleaf.

Table: 1a: SAMPLE PROFILE CHART-Name of Block/Name of Village/Name of District Cross-tabulation

NAME OF DISTRICT												TOTAL
Tinsukia	**Name of Block**	**Itakholi**					**Hapjan**					2
	Name of village	Mahakali T.E.	Borjaan (Pagola Basti)	Monkhadi Gaon	Bahadur bagan	Dewhaal	Anandabag T.E.	Hahsara	Begenabari	Digha Tarang T.E.	Lesengka Bongali Gaon	10
	Respondents	10	9	11	10	10	10	10	11	7	9	97
Darrang	Name of Block	**Pub-Mangaldoi**					**Pachim-Mangaldoi**					2
	Name of village	Balabari	Bandia	Chaukhuwa	Dhula	Abhaypukh	Ramhari	Nagarbahi	Chapai	Dashi	Upahupar	10
	Respondents	10	10	8	10	9	9	10	10	10	10	96
Bongaigaon	Name of Block	**Dangtol**					**Srijangram**					2
	Name of village	Chokapara	Ghandal	Mazgaon	Siponchila	Jakuapara	Pakhiriguri	Mojaimukh	Lengtisingapara	Gunisiguri	Nankola	10
	Respondents	10	10	10	10	10	10	10	10	10	10	100
Golaghat	Name of Block	**Morongoi**					**Sarupathar**					2
	Name of village	Panikora	2No. Koibatra	Sesamukh	Telia Gaon	Patkotis	1 No. Tengakhola	Moran Gaon	2No. Tengakhola	Gondhkoroiguri 2	Latajuri	10
	Respondents	10	10	10	10	10	10	10	10	10	10	100
Sonitpur	Name of Block	**Sootea**					**Biswanath Chariali**					2
	Name of village	Ghahigaon	Pathekakuri	Habidoloni	Bhuyan para	Hokajan	Panibharal	Balipukhuri	Gorehagi	Bhirgaon	Maral Gaon	10
	Respondents	10	10	10	10	10	9	9	9	9	8	94
												Total = 487

Table: 1b: SAMPLE PROFILE CHART-Name of Block/Name of Village/Name of District Cross-tabulation

NAME OF DISTRICT												TOTAL
Kamrup	Name of Block	**Hajo**					**Boko**					2
	Name of village	Manahkuchi	Hadala	Gerua	Kalitakuchi	Bardadhi	Dakuawapara	Behuwa	Dilinga	Hahim	Pakhrapara	10
	Respondents	9	9	9	9	9	9	10	9	9	10	92
Dibrugarh	Name of Block	**Borboruah**					**Khowang**					2
	Name of village	Lezai	Bokpara	Tekela Siring	Jamira Kapou Gaon		Khowang Kawoimari Gaon	Duloniku r	Kumaraon	Bukakhola		8
	Respondents	11	10	10	10		9	10	10	9		79
Cachar	Name of Block	**Silchar**					**Borjalenga**					2
	Name of village	Saidarpur IV	Chandrapur I	Daspara	Ambikapur 10	Chottojalenga	Durabond	Rosekandi	Silcoorie	Loharbond	Bariknagar	10
	Respondents	7	7	10	8	9	10	3	8	4	9	75
Jorhat	Name of Block	**Sipahikhula**					**Baghchung**					2
	Name of village	Diha Gajpuri	Kamar Khatowal	Bam Kukurasuwa	Dewan Gaon	Korchoguri Gohain Gaon	Cinnamara Sadar	Cinnamara T.E. 2 no Line	Cinnamara Bar Bangia	Na Ali Kamalabari	Cinnamara Buddha Mandir	10
	Respondents	10	10	8	9	10	10	10	10	10	10	97

Total = 343
Grand Total = 487
+343
830

For qualitative analysis, the researched were identified through purposive and snowball sampling. Two aspects of the study were explored through the qualitative method. One, to trace the connection between violence and mental disorders among women and another to study dissociative behaviour among women as culturally conditioned idioms of mental distress rather than as psychopathologies. Purposive sampling enabled identification of cases keeping in mind the following inclusion/exclusion criteria:

- ✓ Married and unmarried women suffering from mental disorders as a result of being exposed to violent, traumatic life events. Thus, victims of labeling, domestic violence, trafficking and violent circumstances whose mental health has been affected by the same were considered for the study.
- ✓ Married and unmarried women reflecting dissociative behaviour. Women who claimed to have been possessed at some or the other point in their lives and those who professed to have entered into trance states were sought. The researched were sought out from different ethnic backgrounds in order to study how different cultural contexts lent their touch on the psychological constitution of its people.
- ✓ Married and unmarried women with common mental disorders. Women suffering from severe disorders or psychoses were excluded as the same is believed to have organic basis rather than being triggered by social factors, and therefore out of the purview of the study.

The cases were identified through NGOs (Tezpur District Mahila Samity and North Eastern Regional Multipurpose School and Handicapped Training Centre, Balipara), informal networking at the outpatient department of Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, friends and professional associates. Some of them further introduced the researcher to others who fitted into the defined criteria, thus snowball sampling was also employed in identifying the researched.

The study did not preconceive the exact number of cases to be studied; rather the researcher used her discretion in this regard. The focus was to gather a diverse range of cases in order that all nuances of the study were adequately addressed. Whether to explore the effect of violence on women's mental health or to study dissociative behaviour as culturally affected idiom of distress, the researched were identified to testify the premeditated connect.

The number of cases addressing each aspect of the study is not uniform; rather the same has been determined by what the field had yielded of its own accord. The researcher only ascertained that adequate number of cases, in each category, was studied to justify the hypothesis forwarded by the present study. Table 1 c, d and e provide a preview of the cases studied for quanlitative analysis.

Table 1c: Profile of the Researched (victims of violence)

Sl. no	NAME	Age	Marital Status	Brief History
1	Shilpi Das	18 years	Married but Separated	Victim of Domestic Violence
2	Ruma Nath	Between 30 - 35 years approx.	Married but Separated	Victim of Domestic Violence
3	Suranjana Devi	Between 30 - 35 years approx.	Widowed	Victim of Domestic Violence
4	Aradhana	62 years	Married	Victim of Domestic Violence
5	Lata	18 years	Unmarried	Victim of Trafficking
6	Bani	18 years	Unmarried	Victim of Trafficking
7	Ankita Hajong	Between 30 - 35 years approx.	Married but separated	Victim of Rape

Table 1d: Profile of the Researched (women who have been possessed or practice trance rituals)

Sl. No	NAME	Age	Marital Status	Brief History
1	Probha	Between 45-49 approx.	Married	Claims to have been possessed by spirit
2	Firoza Khatun	24 years	Married	Claims to have been possessed by Jinn
3	Menuka	Between 55-59 years approx.	Married	Claims to have been possessed by Goddess Durga
4	Shreya	Between 25-29 years approx..	Married	Performs trance rituals
5	Manori Basumatary	50 years	Married	Performs trance rituals

Table 1e: Profile of the Researched (labeling and mental health)

Sl. No	NAME	Age	Marital Status	Brief History
1	Basudha	Between 45-49 years approx.	Single	Labelled as mad, the woman developed distress symptoms

1.4.5 Ethical Issues

Research on mental health is a sensitive domain that necessitates that identity of the respondents is not divulged. Therefore, the present study adopted the following measures towards securing personal details of the researched:

- ✓ The participants were informed of the purpose of the study and their voluntary participation was solicited. Informed consent was sought both from the respondents as well as their family members

- ✓ In order that the identity as well as the information shared by the researched remains confidential, the same have been assigned pseudo names and the location of their residence has not been divulged in the study. The researched were made aware that their narratives would neither bear their names nor their residential address.

1.4.6 Data Collection

For quantitative analysis the data was collected through structured questionnaire developed for the purpose. Close-ended questions were posed before the respondents along with corresponding set of answer option. The response was recorded on each schedule which was later on analyzed. This method of data collection suited well the researcher's intent to elicit respondents' opinions, attitudes, feelings, and perceptions on the concerned issue.

For qualitative analysis, however, interview guides were used for data collection. A semi structured interview guide was preconceived covering the following areas:

- ✓ Social background of the researched
- ✓ Life events that have led up to the present condition of the researched
- ✓ Detailed description of the symptoms of distress
- ✓ Personal narrative of the researched on the turn of events of their lives
- ✓ Institutional help, if any, received and the course of treatment
- ✓ Present life situation
- ✓ Social response towards the researched (researched's perception)

The interview guide, however, left enough space to probe into other aspects of the researched's life and social circumstances if it was so required. New dimensions of analysis were chanced upon in the process of interaction with the researched, which enriched the scope of the stipulated interview guide. In-depth interview was conducted which generated rich descriptive data on the researched's experience and perceptions.

1.4.7 Data Analysis

Quantitative analysis was done using Statistical Package for Social Science to analyse the relationship between different variables of the study. Simple statistical tools like frequency, mean, cross-tabulation and chi square test were used for analysis as well.

The analysis process entailed feeding the data into computer database and screening the same for duplicate records, range check, error search, and classification of variable and formation of new variables. The summarized data has been, thereafter, represented as frequencies, percentage (%), charts, diagrams and cross-tabulations.

Qualitative analysis followed the principle of narrative inquiry, as this tool enables the sharing of vital knowledge in an informal story telling mode. Not merely a tool for data collection and processing, it is also an effective method of conveying felt emotions, thereby infusing life and meaning to the experience narrated by the researched. Having its origin supposedly in narratology, hermeneutics, structuralism and literary traditions such as discourse analysis and feminism , this method facilitates a self-reflexive "inquiry into the social phenomena that encompass individuals' personal and collective biographies and social history" (Giddens, 1991; Taylor, 1991 cited in Goodson and Gill, 2011, 18).Narrative inquiry facilitates a probe into the way human beings experience the world they live in and the researcher role herein is to encapsulate and represent the same. This method is suited well in understanding the field in an in-depth manner, its structure, culture and ethos and therefore rises above the limitations of positivist research (Goodson and Gill, 2011). Qualitative inquiry has enabled the researcher to delve into the lives and experiences of the women to elicit rich data for the study. Whether in the case of women who narrated episodes of violence in their lives or in that of those who recounted their experience of possession, trancing and altered state of conscious, this mode of enquiry has helped to unfurl the depth and complexity of their experience and associated socio-cultural dynamics enabling the researcher to study the

manifold layers of the phenomenon under consideration (Plummer, 2001 cited in Goodson and Gill, 2011).

This method is particularly relevant in documenting the subjective experience of the researched as and how lived by the researched with the role of the researcher relegated to conveying the nuances of the experience from the perspective of the researched in an interpretative manner rather than to actively construct "categories for an understanding of the causal effects and outcomes of human actions" (Goodson and Gill, 2011, 22). The personal experience and worldview of the researched, thus captured, has lent the present study its unique essence.

1.4.8 Chapterization plan

The study has been laid out in the following chapters that ensue hereafter:

- ✓ Theories, Concepts and Literature: An Overview
- ✓ Cause and Consequence of Women's Mental Disorder: Perspectives on the Social-Epidemiological Connect
- ✓ Violence and Mental Health: Perspectives on Mental Health Sequelae of Violence against Women
- ✓ Culture and Mental Health: Perspectives on Culture Impacted Idiom of Women's Mental Distress
- ✓ Conclusion

References

Addlakha, R**.** (2008). *Deconstructing Mental Illness: An Ethnography of Psychiatry, Women, and the Family*. Zubaan Books, New Delhi.

Afifi, M. (2007). Gender differences in mental health. *Singapore Medical Journal*, 48(5): 389-391.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders.* American Psychiatric Association, Washington, DC, 4th edition. Retrieved on 7 June 2016 from https://justines2010blog.files.wordpress.com/2011/03/dsm-iv.pdf

Astbury, J. (2001). Gender disparities in mental health. In *Mental health: A call for action by World Health Ministers,* pages 73-92, World Health Organization, Geneva.

_____. (1969). *Symbolic Interactionism: Perspective and Method*. University of California Press, Berkeley.

Borrell-Carrió, F. et al. (2004). The biopsychosocial model 25 years later: principles, practice, and scientific inquiry. *Annals of Family Medicine*, 2(6):576-82.

Busfield, J. (1996). *Men, Women and Madness - Understanding Gender and Mental Disorder*. New York University Press, New York.

_____. (2000). Introduction: Rethinking the Sociology of Mental Health. In Busfield, J.,editor, *Rethinking the Sociology of Mental Health*, pages 1-14, Blackwell Publishers, Oxford.

Castillo, R. J. (1997). *Culture & mental illness: A client-centered approach*. Pacific Grove, Brooks/Cole Publishing, 1st edition.

Census. (2011). *Assam Population Sex Ratio in Assam Literacy rate data*. Retrieved on 20 Dec. 2015 from http://www.census2011.co.in/census/state/assam.html

Chesler, P. (1972). *Women and Madness*. Avon Books, St. Martin's Griffin, New York.

Davar, B. V. (1999). *Mental Health of Indian Women: A Feminists Agenda*. Sage Publication, New Delhi.

Deacon, Brett J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, 33: 846–86.

ENVIS Centre Assam. (2017). *Demography in Assam*. Retrieved on 15 Mar. 2017 from http://asmenvis.nic.in/Database/Hindi/Demography_843.aspx?format=Print

Foucault, M. (1988). *Madness and civilization: A history of insanity in the Age of Reason*. Vintage Books, New York.

Ghaemi, S.N. (2009). The rise and fall of the biopsychosocial model. *British Journal of Psychiatry*, 195(1):3-4.

Goodson, I. F. and Gill, S. R. (2011). The narrative turn in social research. *Counterpoints*, 386:17–33.

Horwitz, Christopher. (2010). An Overview of Sociological Perspectives on the Definitions, Causes, and Responses to Mental Health and Illness. In Scheid, T. L. and Brown, T.N., editors, *A Handbook for the Study of Mental Health*, pages 89-105, Cambridge University Press, New York. 2nd edition.

Jick, Todd J. (1979). Mixing Qualitative and Quantitative Methods: Triangulation in Action. *Administrative Science Quarterly*, 24(4): 602-611.

Kakar, S. (1997). *Culture and Psyche: Psychoanalysis and India*. Oxford University Press, New Delhi, 2nd edition.

Kessler, R.C. (2009). The global burden of mental disorders: an update from the WHO World Mental Health (WMH) surveys. *Epidemiologia E Psichiatria Sociale*, 18(1):23-33.

Keyes, C. L. M. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behaviour*, 43(2):207-222.

Keyes, C. L. M. and Michalec, B. (2010). Viewing mental health from the complete state paradigm. In Scheid T. L. and Brown T.N., editors, *A Handbook for The Study Of Mental Health: Social Contexts, Theories, and System*, pages 125–134, Cambridge University Press, New York.

Kinderman, Peter. (2005). A Psychological Model of Mental Disorder. *Harvard review of Psychiatry*, 13(4): 206-217.

Link, Bruce G. and Phelan, Jo C. (1989). Labeling and Stigma. In Scheid, T. L. and Brown, T.N., editors, *A Handbook for the Study of Mental Health,* pages 64-88, Cambridge University Press, New York.

Murthy, R.S. (2011). Mental health initiatives in India (1947–2010). *The National Medical Journal of India*, 24(2): 26-35.

Peterson, Christopher. (2010). Psychological Approaches to Mental Illness. In Scheid, T. L. and Brown, T.N., editors, *A Handbook for the Study of Mental Health,* pages 89-105, Cambridge University Press, New York.

Pilgrim, D. (2002). The biopsychosocial model in Anglo-American psychiatry: Past, present and future . *Journal of Mental Health*, 11: 585–594.

Reddy, V.M. and Chandrashekar, C.R. (1998). Prevalence of Mental and Behavioural Disorders in India : a meta-analysis. *Indian Journal of Psychiatry*, 40(2):149-157.

Rogers, A. and Pilgrim, D. (2005). *A Sociology of Mental Health and Illness*. Open University Press, United Kingdom. 3rd edition.

Rosenfield, S. and Smith, D. (2010). Gender and Mental Health: Do Men and Women Have Different Amounts or Types of Problems? In Scheid, T. L. and Brown,

T.N, editors, *A Handbook for the Study of Mental Health*, pages 106-124), Cambridge University Press, New York.

Scheff, T. J. (1966). *Being mentally ill: A sociological theory*. Aldine Pub. Co, Chicago.

Scheid, T. L. and Brown, T.N. (2010). Approaches to Mental Health and Illness: Conflicting Definitions and Emphases. In Scheid, T. L. and Brown, T.N. editors, *A Handbook for the Study of Mental Health*, pages 106-124, Cambridge University Press, New York.

Schwartz S. and Concoran, C. (2010). Theories of psychiatric disorders: A sociological analysis. In Scheid, T. L. and Brown, T.N., editors, *A Handbook for the Study of Mental Health*, pages 64-88, Cambridge University Press, New York.

Selye, H. (1950). Stress and the General Adaptation Syndrome. *British Medical Journal*, 1(4662): 1383-1392.

_____ . (1975). Stress and Distress. *Comprehensive Theory*, 1(8):9-13.

Showalter, E.(1987). *The female malady: Women, madness and English culture 1830-1980*. Penguin Books, Harmondsworth and New York.

Sinha, S.K. and Kaur, J. (2011). National mental health program: manpower development scheme of eleventh-five year plan. *Indian Journal of Psychiatry*, 53: 261-265.

Westerhof ,G. J. and Keyes, C.L.M.(2009). Mental Illness and Mental Health: The Two Continua Model across the Lifespan. *Journal of Adult Development*, 17(2):110-119.

World Health Organization. (1986). *Ottawa Charter for Health Promotion.* World Health Organization, Geneva. Retrieved on 23 Aug. 2016 from http://www.who.int/healthpromotion/areas/en/

World Health Organization. (2001). *Mental Health: A Call for Action by World Health Ministers*. World Health Organization, Geneva. Retrieved on 7 June 2016 from http://www.who.int/classifications/icd/en/bluebook.pdf

_____. (2003). *Investing in Mental Health*. World Health Organization, Geneva. Retrieved on 7 June 2016 from http://www.who.int/classifications/icd/en/bluebook.pdf