CHAPTER- 2

Theories, Concepts and Literature: An Overview

The present study is an endeavor to explore the impact of socio-cultural factors on mental health of women. In order that a holistic assay may be conducted on the role played by socio-cultural factors in shaping mental health of women, an array of social stressors have been studied. Further, the study has also brought within its purview stigma attached to women suffering from mental disorders as well as culturally condoned expressions of distress experienced by women in the course of their everyday lives. Thus, the present study has delved into myriad aspects related to mental health of women which has been informed by a plethora of scholastic work on the concerned subject. The present chapter presents a précis of the theories and concepts that have lent their influence on the study. Further, the chapter also provides an overview of the literatures that have been referred to with the view to substantiating the argument forwarded by thesis.

2.1 Theoretical Framework of the Study

This section discusses the theoretical frame work that has informed the study. Some of the frameworks elucidating the relation between mental health and social factors have been discussed here with the view to explaining the social causation of mental disorder. The core tenet of the thesis lies in directing attention to the socio-cultural factors that possess the potential to cause mental disorders and in refuting the exclusivist claim of natural sciences in explaining mental disorder in terms of bio-genetics alone. The theories explored below provide an insight into the effect that socio-cultural lives of individuals have on their mental health.

2.1.1 Stress Theory

The premise of this theory is built on the assumption that physical and mental well-being of individuals rest upon the maintenance of equilibrium of life or homeostatsis (Canon, 1929 cited in Schneiderman et. al, 2005) and the term stress as postulated by Selye (1950) hints at the negative influence of environmental factors that bring about a

disturbance of this equilibrium. Events that pose as threats to homeostatsis have been identified as stressors by Selye, who also established through his experiments on animals, that prolonged exposure to noxious environmental stressors or stressful events result in diseases. In this context Selye forwarded his concept of General Adaptive Syndrome (G.A.S) which is the "nonspecific response of the body to noxious stimuli" (Selye, 1950, 4667), in other words the process whereby the body responds to a stressful situation. According to Selye, the G.A.S consists of three universal phases whereby the body attempts to adapt to the environmental stressors. The first of these three phases is known as the alarm reaction in which the body strives to fight the stressor or attempts flight, i.e. to escape from the same. However, this state of excitement cannot be sustained for long and paves the way for the second phase where the body builds its resistance against the stressor. In case of prolonged exposure to a stressor, the body slips into the phase of exhaustion that eventually culminates in disease or death. (Lyon, 2012). Selye's experiments were based on laboratory animals and intrigued many researchers to explore the same connect between social stressors and physical and mental health of human beings. Holmes and Rahe (1967 cited in Thoits, 2010), in this context forwarded their claim that life events could become potential stressors that call for behavioural adjustments in the lives of individuals and that a continued exposure to such events could weigh on the individual's ability to adapt thereby making them vulnerable to disease and degeneration. Some of the life events suggested by them include death of a spouse; divorce; marital separation; imprisonment; death of a close family member, personal injury or illness, marriage, dismissal from work, retirement etc. Importantly, this exploration has served well the interests of the researchers on mental health, who, drawing from the same suggest that life events could also have a deleterious effect on mental health. Thoits (2010) brings to fore the suggestion of Homes and Rahe that both positive and negative life events call for adjustment and have the potential to cause stress, nonetheless, it is the negative life events that pose threat to mental health.

Childhood and adolescent exposure to stressors such as sexual abuse, broken home, neglect etc. have been found to result in mental disturbances such as provocative

behaviors, avoidance of intimacy, and disturbances in attachment (Haviland et al. 1995; Lowenthal 1998 cited in Schneiderman et. al., 2005). A neglected or abused childhood often results in learning disability, poor social behavior, anxiety and depressive tendencies. Further, protracted exposure of children to social turbulence such as war and terrorism have also taken its toll on their mental health as pointed out by Nader et al. (1993 cited in Schneiderman et al., 2005) who have brought out the fact that 70% of Kuwaiti children reported mild to severe PTSD symptoms after the Gulf War and as projected by Macksound and Aber (1996 cited in Schneiderman et. al, 2005) who have found that 43% of Lebanese children exhibited post-traumatic stress symptoms even ten years after being exposed to war-related trauma. In the case of adults, stressful life events like divorce, unemployment, loss of close relatives etc. have been found to trigger depression (Kessing et. al, 2003 cited in Schneiderman et. al, 2005). Prolonged exposure to stressful events has also culminated in anxiety disorders as several other studies have revealed (Faravelli and Pallanti 1989; Finlay-Jones and Brown 1981 cited in Schneiderman et al., 2005).

However, not all individuals respond to stressors in the same way as coping resources of individuals vary. Greater the social support an individual enjoys more is the coping resource at her/his disposal. Individuals with high self-esteem and with a greater sense of control over their lives are well disposed to tackle the stresses of everyday life while those others who are socially disadvantaged, lacking self-esteem and with perceived lack of control over their lives succumb to the stressors easily. Going by this logic, the women, the elderly, the very young, the unmarried, and those of low socioeconomic status are more vulnerable to social stressors (Turner, 1995; Turner and Marino, 1994; Turner and Roszell, 1994 cited in Thoits, 2010). Thus the stress theory not only explains the social-etiological connect with respect to mental disorder but also emphasizes on the vulnerability of the socially disadvantaged groups. Nonetheless, this theory is saddled with a few limitations, for instance it does not explain the susceptibility of some individuals to mental disorders and not others (Schwartz and Meyer, 2010), though it does a fairly credible job in explaining why socially disadvantaged groups are exposed to more social stressors and therefore more

vulnerable to mental disorders. Moreover, it does not clarify as to why some groups are more susceptible to one kind of disorder while other groups reflect greater propensity for other kinds of disorders (for example, why women are prone to depression and anxiety disorders and why men develop antisocial personality disorder and more often abuse drugs and alcohol) (Thoits, 2010). Stress theory is also better equipped to explain common mental disorders like depression and anxiety issues rather than psychoses, a wholesome explanation of which cannot be furnished without roping in the genetic and biological causal factors. Notwithstanding these limitations, stress theory provides a credible frame for explaining the social etiology of mental disorder and therefore is one of the important premises for consideration in the study

2.1.2 Structural Strain Theory

Structural strain theory is a compendium of hypotheses that attempt to explain social etiology of mental disorder. It invites attention to social structure, organization and hierarchy which are favourably disposed towards certain groups to the detriment of the others. One of the prominent theories commonly referred to under this school of thought is Merton's anomie theory which explains deviant behaviors among individuals. Merton conceptualized anomie as the lag between culturally valued goals and the structural or social factors that either resist or hinder realization of the same. Merton suggests four specific adaptive mechanisms (enumerated below) whereby individuals adapt to this lag between personal aspirations and structural barriers that foil the same:

1. Conformity - mechanism whereby an individual treads the conventional path in order to achieve the goals of life
2. Ritualism – mechanism whereby an individual adheres to conventional and normalized means of achieving goals even though the same may not lead to fulfillment of the same.
3. Innovation – mechanism, often illegitimate and contravenous, adopted by individuals in pursuit of goals

4. Retreatism – a state of mind where an individual relinquishes all attempts of goal realization and withdraws from all legitimate avenues of self-actualization.
5. Rebellion- whereby individuals reject the socially endorsed goals as well as the means to achieve the same. (Thoits, 2010)

According to Merton, the latter three explain deviant behavior among individuals. Drawing from the above, mental disorder can be averred as a response to the structural strains, a deviant behavior elicited by hierarchical organization of the society that impedes realization of aspirations for some groups and members of the society. Thus, structural strains manifested in social and economic systems that thwart the prospects of some groups, contribute towards mental disorders among the same. A precursor to Merton's theory was Durkheim's analysis of the social causes of suicide, in which the French sociologist had drawn a veritable link between social factors and their impact on suicidal tendencies of members of a society. Durkheim had drawn attention to social norms which function towards regulation and integration of society in explaining the causes of suicide. Durkheim explained four types of suicide, triggered by social factors, *viz*. egoistic, altruistic, anomic and fatalistic (1951). In Durkheim's view norms or socially contrived rules serve to contain our impulses and unrestrained emotions within reasonable limits. In the absence of such regulatory forces, uncontrolled emotions and unfulfilled aspirations among individuals may surmount and culminate in egoistic suicide. However if social integration is way too strong, individual impulses and passions may be subdued by that of the collective, and may bring about altruistic suicide (where securing the interest of the group warrants sacrifices at individual levels). Anomic suicide arises out of normlessness that is created when societies undergo substantial changes that its members find difficult to grapple with (Thoits, 2010). Finally, fatalistic suicide is caused by a society, in which the norms are overtly oppressive and binding on individuals, where suicide becomes the only means of respite from the insufferable conditions. Thus, Durkheim indicates at structural strains (such as overbearing norms or an absence of the same) as causes of greater incidences of suicide in a particular society. Several studies, thereafter, have amply endorsed the fact that

structural strains do bear upon mental health. Notably that of Faris and Dunham's study which has revealed how poverty and squalor have substantially contributed in causing schizophrenia among groups thriving under such conditions. This theory has expressly indicated at socially strained conditions such as economic deprivation, conflict ridden circumstances, single-headed families, restricted employment opportunities and discrimination as negative factors that can potentially exacerbate mental disorders of individuals and groups (Aneshensel, 1996; Silver, Mulvey, and Swanson, 2002; Stockdale et al., 2007 cited in Thoits, 2010). Another important aspect for consideration here, as highlighted by this theory, is the role ascribed for different individuals in a society.

> *Roles* are sets of reciprocal rights and obligations attached to specific positions in the social structure, such as husband–wife, parent–child, teacher–student, and physician–patient. These rights and obligations tell incumbent how to act in relationships with other people and why they should do so. Thus, roles provide behavioral guidance and supply individuals with purpose and meaning in life (Thoits, 2003 cited in Thoits, 2010). Given this, people who have few or no social roles are at greater risk of engaging in deviant behavior (e.g., drug or alcohol abuse, aggressive or impulsive acts) and experiencing anxiety or despair. (Thoits, 2010, 118)

This accounts for greater incidence of mental disorders among women, and other socially underprivileged groups whose roles are limited and trivialized in a society. This theory largely hints at socio-economic structures and their role in causing mental distress and disorder. According to Peggy Thoits, by suggesting that social systems, institutions and community contexts may induce strain and result in mental disorders, this theory expands the horizon defined by the biological and psychological theories and emphasizes on the impact of the social paraphernalia on mental disorders (2010).

2.1.3 Labeling Theory

Labeling Theory makes the suggestion that people behave in socially deviant ways when they are perceived and labeled as deviant (Scheff, 1966). Thomas Scheff, the chief proponent of this theory attributed the production of mental disorders in a society to the process of labeling. Labeling enforces an identity upon the labeled, which the latter internalizes and manifests in one's behaviour (Nalah and Ishaya, 2013). Deviance in this context refers to behavior that contravenes the normative and socially endorsed ideals of conduct and living. Deviance is not enrooted in the persona or behavior of an individual, rather is a socially constructed idea fixed on behaviors, thoughts and attitudes that do not conform with the established norm, hence this theory is also known as the societal reaction theory (Thoits, 2010). In the context of mental health, symptoms of mental disorder are perceived as violation of normative conduct and therefore invite social sanction. Once a person has been labeled as mentally disordered, an array of negative imagery is attached to the same. The person acquires an identity that has been shaped by societal reactions and in time externalizes the attributes that have actually been extraneously heaped on her/him. Thus according to Scheff (1966) mental disorder is but a social role induced by the way society responds and reacts to behaviours it considers as deflecting from the normative path. Further, Scheff explains that hospitalization reinforces the label attached to an individual by publicly endorsing the same. The individual then embraces the labeled identity even more deeply and plays out the labeled role accordingly. "This process is an example of a "self-fulfilling prophecy" (Merton, 1938/1968 cited in Thoits, 2010). … Mental illness becomes the issue around which one's identity and life become organized – it becomes a "deviant career" (Thoits, 2010, 121)." For one thus labeled, it is difficult to ever shrug off the identity as the same becomes the basis on which one is evaluated by society as well as by the self. The differential treatment, elicited by the stereotypical assumptions about the mentally disordered, to which an individual is subjected by the society stabilizes her/his identity as mentally disordered over time and the imagery fixated on the individual impels her/him to behave in conformation with the same (Scheff, 1966).

Labeling theorists (Becker, 1973; Lemert, 1951; Scheff, 1984 cited in Thoits, 2010) opine that all members of a society violate some norm or the other at different points in their lifetime; however the same is ignored if it has a short term impact and is not repeated over time. This is termed as primary deviance and considered inconsequential, whereas, deviant behaviours that are oft repeated, severe and perpetrated by those lower in the social rung than the agents of social control meet with a stronger social sanction. The latter is termed as secondary deviance. Scheff (1966) reflects on certain social attributes (discussed below) that make an individual more vulnerable to being labeled.

A. Power and Resource

Individuals who are in a position to exploit resources and wield power are less vulnerable to the process of labeling than those who are powerless and devoid of resources. This suggests that the socio-economically indigent are more likely to be labeled.

B. Level of tolerance towards deviance

Societies that harbor an intolerant attitude towards deviant behaviour are more prone to labeling. It has also been suggested here that the attitude of tolerance is less towards the marginalized sections that thrive on the fringes of the society than those that are well integrated in the same. Thus, the underprivileged members of a society are more prone to being labeled.

C. Social Distance

The labeling theorists have made an important point by suggesting that when the social distance between the labeler and the labeled is more, that is to say that if the latter belongs to the marginalized section and the former hails from the section that is privileged to exercise social control then the process of labeling is inevitable, than in a situation where the social distance between the two is not as chasmal.

D. Visibility of the deviant behavior

The more visible a deviant behaviour is to the onlooker, the more likely it is for the process of labeling to take place. If the deviant behaviour is not conspicuous, it is possible that the one who commits the same may escape being labeled.

The labeling theory has been considered by many as radically sociological, as the same stands to subvert the claims forwarded by the biological and psychological perspectives by asserting that mental disorder is neither located in the biology nor the psyche, rather in the social context one is wrapped in. Deviance or disorder in this regard is not intrinsic to an individual rather a consequent offshoot of the application of rules and sanctions on perceived deviance (Becker, 1973). The theory has also courted a lot of criticism, particularly from Walter Gove, who voiced his clear dissent with the proposition made by Scheff. According to Gove, labeling does not induce further deviant behaviour nor does it precede illness. Rather labeling is a consequent of deviant behaviour projected by an individual. He categorically stood in contention to the claim that labeling has a pernicious influence in stabilizing the identity of an individual as mentally disordered (Link and Phelan, 2010). The labeled individual is not a passive recipient of the same; rather the process of labeling is a dynamic construct that is triggered by the psychopathology of the individual rather than by any extrinsic motive. This protracted quarrel between the two opposing stances lead to the emergence of the modified labeling theory, principally contributed by Bruce Link.

In the modified labeling theory, Link (1989) steers clear of endorsing the causal effect of labeling on an individual’s mental health. The most relevant point made by the modified labeling theory is how the labeling of the mentally disordered individual and the subsequent attachment of a stigmatized identity on her/him obstructs active participation of the same in personal, social and professional arenas. Labeling has a deleterious effect on the self-esteem of the individual and thwarts her/his prospects of life. His thrust is on the process whereby labeling and stigma hinders the life prospects of the mentally disordered. Link suggests that as a part of socialisation people

internalize presumptions on the social repercussions of being mentally disordered. The apprehension of being rejected, devalued and discriminated against impels the mentally disorderd to recourse to any of the three adaptive responses:

i. maintaining secrecy about one's condition
ii. withdrawing from social contact
iii. educating others with view to dispelling negative presumptions about mental disorder.

These coping mechanisms may, however, rebound adding to the despair, distress and isolation of the individual. Therefore, Link makes the suggestion that it is the apprehension of facing social rejection, rather than the actual responsive behaviour of others which escalates the suffering of the mentally disordered. This argument is well summarized in the words of Link and Phelan, who state that

> …expecting and fearing rejection, people who have been hospitalized for mental illness may act less confidently and more defensively, or they may simply avoid a potentially threatening contact altogether. The result may be strained and uncomfortable social interaction with potential stigmatizers (Farina et al., 1968 cited in Link and Phelan, 2010), more constricted social networks (Link et al., 1989 cited in Link and Phelan, 2010), a compromised quality of life (Rosenfield, 1997 cited in Link and Phelan, 2010), low self-esteem (Wright, Gronfein, and Owens, 2000 cited in Link and Phelan, 2010), depressive symptoms (Link et al., 1997 cited in Link and Phelan, 2010), unemployment, and income loss (Link, 1982, 1987). (2010, 573)

The labeling theory is contestable on several measures, nonetheless, it continues to be relevant in studies on mental health as the same invites attention to the influence of societal reaction in inducing and sustaining mental disorders and challenges the bio-medical and psychiatric hegemony in the domain. More importantly, it holds up the cons

of institutionalization, one of the reasons why modern debate on mental health is advocating for deinstitutionalization and community care.

2.1.4 Symbolic Interaction Theory

Symbolic Interaction Theory, a social psychological theory that emerged in the early twentieth century put forth the idea that the world inhabited by people is socially constructed and that the personality assumed by individuals is shaped and conditioned through social interactions. Though rudimentary traces of the theory may be linked to Max Weber, who articulated on the subjective meaning of human behaviour (wherein he argued that human behaviour ought to be rationalized in it specific social context), the present theory is largely linked to George Herbert Mead. Mead spells out 'mind' and 'self' as two distinguishing aspects of humans which develop in the course of social interaction. Mead explains 'mind' as the specific human faculty that is disposed to making a choice between the alternate courses of action that one may adopt to articulate the best response to a social situation while, the 'self' is the persona of the individual that develops in interaction with and emulation of a stable set of social attitudes (Bhattacharjee et al., 2011). However to Mead, the social is the precursor of the personal, therefore the individual 'self' and 'mind' are necessarily social emergents. No individual is endowed with 'self' at birth, but develops the same through active interaction and engagement with the generalized other, meaning the other members of the society as well the socially endorsed values and behavours (Mead 1934).

An essential element in the formation of the 'self', as explained by Mead (1934) is the process of role taking which is but an amalgamation of imitative responses, gestures and conversations acquired through engagement of an individual with the social space in which she/he is located. This process enables the individual to shape her/his own attitude, behaviour and response to others in sync with that of the collective attitude. Mead explained the development of the self as a process of taking the role of the 'other,' or as he called it, the 'generalized other'. Thereon, Mead (1934) progresses to explain

his concepts of ‘I’ and ‘me’, which are both aspects of the individual persona. The ‘me’ develops through socialisation, where the individual personality assumes the attributes of the social collective and ‘I’ is the response of the individual to the society and its norms or in other words to the generalized other. Thus the ‘self’ is a conjugation of the ‘I’ and ‘me’ and is deeply embedded in the social context.

Stryker (2008) informs us that according to Mead individuals and society are interdependent. In his words, “both persons (humans with minds and selves) and society are created through social process; each is constitutive of the other, and neither has ontological priority. Society emerges out of interaction and shapes self, but self shapes interaction, playing back on society” (17). However, Mead does not perceive human beings as mere “automatons bending to intractable social forces while recognizing the potential of social forces to overwhelm them" (Stryker, 2008, 19), rather “provides grounds for recognizing what human beings bring to the histories that produce them…” (Stryker, 2008 , 19) thereby clarifying the role humans have in shaping society as well.

Mead’s ideas were further developed by Herbert Blumer, who summarized the core of symbolic interactionism thus, ‘the peculiar and distinctive character of interaction as it takes place between human beings’ (Blumer, 1962, 179). Blumer rubs in the idea that the self emerges out of social interaction. Blumer’s theoretical premises may be summarized in the following points,

i. actions of human beings towards things are shaped by the meaning they attach to the same
ii. meanings of things are derived though social interactions between individuals and others in a given social context
iii. meanings are derived and modified through the interpretive process employed by individuals in negotiating with things they encounter during social interaction (Blumer, 1969).

He further, asserts that society is not an inconvertible structure, rather is in a state of constant flux owing to its dependence on human agency. Blumer gives due

credence to human actors who are free to act of their own accord and not necessarily bound by an impliable social structure. The interactions and experiences of individuals are not static, and the meanings attached to people, objects and situations are inter-subjective and perceived therefore subject to reinterpretation. Meanings are not pre-determined; they are arrived at in specific social situations through a subjective process of interaction and interpretation. Human behaviour is thence a reaction to the way a situation has been interpreted. Blumer urges that human behaviour be studied in terms of action and that all individuals are capable of independent action and autonomous contributions to social life. This constitutes the distinctive feature of human society where human actors play a vital role in shaping social structures and institutions (Carter and Fuller, 2015).

Another notable contributor to this theory is Charles Horton Cooley, who attempted to explain human behaviour in terms of everyday social interactions. He too emphasized on how individuals attach meanings to different situations and objects and how behaviour is shaped on the basis of the perceived meaning. He famously forwarded the concept of 'looking glass self' (Cooley, 1902), where he suggested that the self develops on the basis of how individuals see others perceiving them. Cooley also introduced the concept of 'primary group' (Cooley, 1909), to indicate at the social group that one interacts with most intimately. This interaction with primary group influences the individual's self-concept. Thus the self is an emergent of social interaction and interpretation of meaning attached to situations and objects encountered in the course of the same. The present theory is of particular relevance to the present study as it refutes the notion of psychic unity as claimed by psychological theories and extols cultural diversity in human personality and behaviour. The argument that human behaviour and self or personality, as it were, is shaped through social interaction and interpretation of meanings attached to objects and situations and therefore variable across time and space is pertinent to the present study. More importantly, the development of the self through the process of role taking explains idiosyncrasies of behaviour as socio-culturally influenced rather than as pathology, another critical facet of the present study. A significant section of this work explores dissociative behaviours as culturally shaped

idiom of mental distress. Symbolic interactionism provides the frame of reference to explain the how cultural imagery unconsciously shapes the psyche of women and how the same is manifested in their dissociative behaviours.

2.1.5 Feminist Theories

Feminists have lent their ideas to the canon of literature on women and mental health. Particularly important in the context of the present study are theories on social construction and social causation vouched by the feminists. Mental disorder has historically been considered a malady affecting the women more than men owing to the former's supposed constitutional frailty. Morally weak, intellectually feeble and physically fragile, women were considered as naturally disposed towards mental disorders. Implicit in this attitude, however, is the rationale to engender control over women and their lives (Showalter, 1987). In a similar vein, Phyllis Chesler in her book *Women and Madness* (1972) hints at how feminine nature is demeaned and pathologised as having an inherent acclivity for madness as she articulates "women, by definition, are viewed as psychiatrically impaired - whether they accept or reject the female role - simply because they are women" (115). Chesler, drawing the influence of anti-psychiatrists like Thomas Szaz, R.D. Laing and T.J Scheff opines that madness is a label that is attached more commonly to women than to men and is a machination intended at controlling them. Further, Chesler makes the point that "gender is intimately linked to madness since it is departures from sex role expectations (or from the expectations of class and ethnicity) that are defined as disordered" (Busfield, 1996, 100). Violation of the socially ascribed masculine and feminine role is condemned as mental disorder. However, the same puts the women in a precarious position as they are perceived mad should they violate the sex role expectations heaped upon them by society. Again, even as they play out the feminine role they are viewed as having a natural predisposition for madness (Chesler, 1972). The feminist argument bear a marked resemblance with the advocates of the labeling theory who made the radical statement that "behaviour considered symptomatic of mental illness was best viewed as a form of deviance and stable or chronic mental illness as a social role" (Busfield, 1988,

530). Societal reaction to rule breaking, according to labeling theorists, is the singularly dominant reason for one to be branded as mentally disordered. The labeling theorists had explained that relative inferior position of certain individuals made them vulnerable to being labeled by those at the helm of power. Feminists harp on this cord to suggest that the inferior position occupied by women in social hierarchy exposes them substantially to the possibility of being labeled. In sync with the formulation of the labeling theorists, the feminists also viewed mental disorder as "socially and historically constructed category which defines phenomena as symptomatic of mental illness and suitable for therapeutic intervention" (Ingleby 1988 cited in Busfield 1988, 531). Thus, the feminists, like the labeling theorists consider non-organic forms of mental disorders as socially constructed label or identity which, however, stands in contradistinction to the bio-medical supposition that projected the same as pathology and subsumed the social and psychological genesis of mental disorders (Busfield, 1988).

Another aspect of the feminist argument that calls for attention is the one that postulates on social causation of mental disorder. Largely the patriarchal structure and its oppressive mechanisms are held responsible for causing stress in the lives of women and affecting their mental health. The stressful factors feature more in the lives of women, as compared to their male counterparts, owing to the social structure that is unfavourably disposed towards women across societies. This accounts for greater incidence of common mental disorders or neuroses among women. Feminists refute the claims of the biologists and psychologists as they explain the aetiology of mental disorder in terms of stress related to different aspects of a woman's life. The feminists also stand in clear contention with the formulation of biological perspective on women's mental disorder as the same stands in denial of women's subjective experiences of their bodies and minds (Davar, 1999). In the words of Bhargavi Davar, "mental illness and breakdown in women may be precipitated by events which are intertwined with women's self-esteem; stress; humiliation or control; caste, class or minority status; and mismatch between expectations and actual reality" (1999, 14). The inferior status accorded to women, the limited resources at their disposal, curtailed autonomy, agency and decision making authority and other hostile features related to a woman's social

situation induces stress in their life. Put succinctly, the feminists contend that the low socio-economic status accorded to women in patriarchal set-ups has a direct bearing upon mental health. Further, the multifarious roles that women are expected to play, more often than not, act as stressors in their lives (Addlakha, 2008).The argument that stress generated by social circumstances prevailing in the life of women may cause mental health problems turns focus on the social aetiology of mental disorder. Feminists, further, argue that women, bound to the home and hearth, experience great frustration which cause deterioration in their mental health (Busfield, 1988). Marital roles including that of child care, as several studies have tarried over, notably that of Gove and Tudor (1973), are causes of stress among women and culminate in deteriorating mental health.

The argument postulated by the feminists provides a frame of reference for the present study that is driven with the intent to substantiate the social epidemiological connect particularly with regard to the lives of women and their mental health. The argument that disparaging social circumstances in which women exist casts a pernicious influence on their mental health is well supported by the feminists claim as discussed above.

2.2 Concepts

The present study is spun around a multiplex of ideas *viz.* mental health, illness and disorder; stress, stressors and distress. Clarity on the concepts employed is, therefore, warranted in order that the ideas discussed in the course of the study are well comprehended. Some important concepts pertinent to the study have been explained here.

2.2.1 Mental Health

The subject of the present study is mental health of women. The term mental health is a dynamic concept indicative of a healthy state of mind which enables human beings

to live productive lives and optimally use mental abilities, whether cognitive, affective or relational (WHO, 1986 cited in Srivastava, 2012). Moving beyond a myopic conceptualization of mental health, which considers the same as a mere absences of illness, mental health has been studied here as a state that includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence and recognition of the ability to realize one's intellectual and emotional potential" (WHO, 2003, 7). Basically, mental health may be understood as a state of well-being in which an individual is able realize one's potential, is able to cope with the stresses of life and make positive contribution towards the society. To express in terse terms, mental health is connotative of a wholesome mental condition that contributes towards development of one's competencies that enable one to achieve one's self-determined goals (WHO, 2003).

2.2.2 Mental Disorder

Mental disorder, as recognized by the Diagnostic and Statistical Manual, 4th edition, of the American Psychiatric Association (DSM-IV, 1994), refers to dysfunctional mental conditions that negatively impact mood, thought, and/or behavior of the afflicted individual. The genesis of mental disorders may be social, psychological, genetic, physical or biological factors and the same commonly results in psychological or behavioral irregularities that debilitate one's social functioning. Mental disorders have a debilitating effect on the individual and impedes one's productive participation in social, occupational, educational and other important areas of life. Mental disorder is a blanket term that encompasses a wide range of mental health problems, ranging from depression and schizophrenia to substance abuse, learning disabilities like dyslexia and age-related degenerative conditions such as Alzheimer disease (Patel and Thara, 2003 cited in Addlakha, 2008). The term mental disorder is therefore inclusive of both the common mental disorders and the severe mental disorders. The present study concerns itself with the influence of socio cultural factors on mental health which, as has been revealed by studies, culminates in common mental disorders. The term mental disorder, therefore, has been used in the chapters following hereafter to indicate common mental disorders.

2.2.3 Mental Illness

The term mental illness is problematic as the same is suggestive of the personal and subjective experience of one suffering from some disease (Boyd, 2000). Therefore, the study consciously opts to use a value neutral term i.e. mental disorder. The term mental illness has been used, but sparingly, in the study to refer to severe mental disorders, for instance schizophrenia, bi-polar disorder, manic–depressive psychosis etc. whose origin is commonly attributed to organic causes (Addlakha, 2008). The present study does not explore the domain of severe mental disorders, rather restricts itself to the study of common mental disorders among women as consequences of the socio-cultural stressors they are exposed to in the course of their lives.

2.2.4 Stress, Stressors and Distress

Stress theory proposed by Hans Selye (1950) explains the impact of external factors on health (in the present context mental health) and has been referred to in the present study in order to understand the noxious influence of socio-cultural factors on women's mental health. Stress theory offers the most cogent arguments in linking socio-cultural factors to mental health (Horwitz, 1999 cited in Schwartz and Meyer, 2010). Furthermore, the frame work of stress theory aids in understanding the prevalence of common mental disorders among the socially disadvantaged (in the present context the women) as a fallout of their exposure to greater stress in the course of their lives, which therefore rationalizes the pertinence of the model to the presence context. Selye viewed stress as a response to external stimuli or environmental stressors (Selye, 1956 cited in Lyon, 2012).In other words, stress signifies a real or perceived disturbance to an organism's physiological homeostasis or psychological well-being (National Research Council (US) Committee on Recognition and Alleviation of Distress in Laboratory Animals, 2008).

Stressors refer to the socio-cultural factors and events that precipitate stress. By way of an explanation, it may be forwarded that external stimuli that induce stress are commonly perceived as stressors. The present work studies a range of social factors viz. religion, marriage, economic deprivation, events such as violence and social processes such as labeling as stressors that have implications for the mental health of the concerned individual, in the context of the study the women, who are exposed to such stressors along the path of life.

Stress can be both positive as well as negative. Eustress (Selye, 1975) is the positive response to stressors while distress is the negative response. Distress may be understood as a negative and adverse response to external stressors that disturb the physiological and/or psychological homeostasis of individuals (Carstens and Moberg, 2000; Moberg, 1987; NRC, 1992 cited in NRC, 2008). Distress is caused when one is exposed to prolonged, cumulative and/or severe stressors, which overwhelm an individual's coping mechanism (Moberg, 2000 cited in NRC, 2008). The argument thrust forward by Bhargavi Davar, that mental disorders in women "are better characterized as 'distress' than as 'illness' because of the strong social aetiology underlying them" (1999, 54) provides the substructure on which the central argument of the research is developed. The negative impact of socio-cultural forces is considered to induce common mental disorders or neuroses among women, whereas psychoses or severe mental disorders are more often than not attributed to biological and genetic factors. Depression, hysteria, somatization, compulsive disorder and dissociative behaviour are distress symptoms more commonly found among women and attributed to the ill-disposed circumstances that typically prevail over their lives. Whereas illness is a medical construct, mental distress constitute the phenomenological experience of women's lives and therefore more pertinent to the scope of the study (Davar, 1999).

2. 3 Review of Literature

This section encapsulates the literature reviewed for the purpose of the study. For clarity of expression the literature has been classified under different topics, each topic corresponds to an aspect relevant to the argument postulated in the thesis.

2.3.1 Perspectives on Mental Health

The domain of mental health has been approached by different schools of thought, each positing its view regarding the cause of mental disorder. The present research aims to study mental health from the sociological perspective. Nevertheless, it takes into cognizance the claims made by the biological as well as the psychological perspectives on the same. Deacon (2002) provides an overview of the biological perspective which is based on the premise that mental disorders are caused by abnormalities of the brain and that the same can be addressed through a treatment protocol much like physical disorders. Owing to the conviction that mental disorder is rooted in biological causes, this perspective reflects a reductive stance that undermines the influence of psychological and social factors on mental health. Deacon points out at the shortcoming of the biological perspective, which in spite of the enthusiastic response it had received for having projected itself as the sole force that could revolutionize the understanding of the nature and treatment of mental disorders was ridden with several failings. Despite the developments in technology, such as brain imaging and molecular genetic testing, this approach failed to identify a single biological marker that could reliably inform diagnosis of any mental disorder. In the face of growing chronicity and severity of mental disorders, the biological perspective proved largely ineffectual in both prevention and treatment of the same. Deacon argues in favour of the bio-psychosocial perspective which fosters dialogue among theoretically and technically diverse perspectives and therefore offers a broader expanse of understanding and addressing issues related to mental health.

Schwartz and Concoran (2010) explain how the biological perspective conceives of mental disorders as akin to disorders of the body, specifically related to the brain. The central argument of the biological perspective, as brought out by Schwartz and Concoran, is that disruptions in brain functioning lead to the development of mental disorder. The three aspects on which this perspective deliberates in order to explain mental disorders *viz.,* (1) brain structure and function, (2) neuronal communication, and (3) genetic effects have been dealt with in an in-depth manner by the authors. This article throws light on a possible amalgamation of biological and sociological perspectives instead of each vying for a mutually exclusive and separatist stand. The marriage between the biological and sociological perspectives would be particularly fruitful in the case of disorders that reflect pronounced social aetiology than in those that have a strong biological underpinning, such as schizophrenia. Further, sociological perspective could hold up the environmental risk factors that are implicated in the aetiology and the course of biologically triggered mental disorders. The interaction between biological vulnerability and sociological factors is laden with possibilities that could strengthen the claim, articulated in the biological perspective, of affecting a revolution in the treatment of mental disorders. To substantiate their claim, the authors draw from the work of other scholars to reflect on how the integrated study of genetic factors and environmental risk factors has led to a better understanding of the cause, course and treatment of mental disorders such as depression. Although an understanding of the biological perspective of mental disorders is important for sociology, the authors also insist on a sociological critique of the biological approach, particularly of the biological reductionism, biological determinism, and the hegemony of biological explanations for mental disorders. Sociologists ought to expose the politics inherent in the ascendance of the biological revolution. Sociologists should probe the dynamics underlying medicalization of social phenomena and labeling of biological differences as biological defects. Further, it is argued by the authors, that the universal classification of disorders with little regard for contextual differences should be critically assessed by the sociologists. It is important that sociologists question the purported overture of the biological perspective towards elimination of stigma associated with mental disorders by locating the cause of the same in biological disposition of individuals, which however,

has met with little success in this regard. Sociological analysis of social construction of mental disorders is pertinent as the number of disorders officially recognized in psychiatry is increasing at an unprecedented rate. The failings of the biological perspective particularly in explaining the cause of increase in the rate of a disorder or differences between disorder rates in different areas warrant a sociological critique. The authors therefore suggest that the sociological perspective should counter the lacunae of the biological perspective and articulate a counter-revolution to the claims forwarded by the latter.

Kinderman (2005) emphasizes on how appropriate conceptualization of the role of psychological factors is salient in understanding mental disorder. Kinderman's article dwells upon the relationship between biological, social, and psychological factors in the causation and treatment of mental disorder. Kinderman posits the view that the biological perspective, notwithstanding its merits, would be partial, scientifically inadequate and shorn of humanistic sensibilities if it fails integrate the social and psychological perspectives in accounting for and addressing mental disorders. Kinderman proffers the psychological perspective as an alternative to that of the biological. He throws light on psychological issues such as experiences and circumstances e.g. childhood sexual abuse, bullying, attachment relations with parents, assault, and all other major and minor interpersonal experiences, that are laden with potential to affect changes to the course of life, as contributing to mental disorder. Importantly, he discusses how the psychological perspective probes into the personal meaning attached to these events in determining the influence of the same on mental health of concerned individuals. It is the disruption or dysfunctions of psychological processes (such as the cognitive process), as brought about by the above mentioned experiences or situations that ultimately lead to mental disorder. Kinderman argues that biological and social factors contribute to mental disorder, however, after being mediated by psychological processes; therefore, the psychological processes are a common pathway that need to be factored in by the biological and sociological perspectives on mental health in understanding the cause and determining the intervention for treatment of mental disorder.

Peterson (2010) holds up the fact that the psychological perspective focuses on individual factors that produce abnormal thoughts, feelings, and behaviors in order to explain mental disorder. Peterson offers a summarized account of the four psychological models of mental disorder, reflecting their stand on human nature, abnormality, and treatment of mental disorder. The four models of mental disorder include the following:

1. Psychoanalytic model, which traces its origin to Freud, projects the hypothesis that people are closed energy systems motivated by an array of drives. This model explains abnormality in terms of development, therefore, the view is forwarded that early childhood events affect the manner in which an adult functions. Under this model, treatment commonly involves aiding the individual to gain insight and release energy from detrimental purposes through cathartic exercises.
2. Cognitive-behavioral approach is the second model discussed by Peterson which focuses on cognition and learning. This model forwards the idea that human beings are information processing systems, whose endeavor lie in maximizing pleasure and minimizing pain. All types of learning (i.e., classic conditioning, operant conditioning, and modeling) ought to be conceived in the cognitive framework as all learning takes place within a thinking context. Abnormalities, as articulated by this model, stem when individuals are situated in highly unusual situations or have unusual ways of thinking. Interventions, under this model, include cultivating adaptive habits and teaching individuals to develop an accurate perception of the world and to address problems of everyday life with efficiency.
3. Humanistic-existential-phenomenological is the third psychological model of mental disorder discussed by Peterson whose chief proponents include psychologists such as Abraham Maslow and Karl Rogers. The focus here is on the need for self-actualization rather than the diagnosis of mental disorder. Individual's experience of the world and the creation of a supportive atmosphere

characterized by genuineness, empathy, and unconditional positive reward conduces mental wellbeing, as is postulated by this model.

4. Family systems model is finally discussed by Peterson, which traces mental disorders to discord within one's family. To address the issue this model vouches for couples or family therapy in which the therapist intervenes to help cultivate healthy relation among family members.

Each model is laden with virtues as well as limitations and may be suited to one or another form of mental disorder, though the same may not be applicable universally. Peterson argues in favour of an integrated approach in which the model most relevant to a particular disorder may be adopted.

Joan Busfield (2000) grounds the rationale for a sociological perspective in academic and clinical explorations of mental health. Recent advances in genetics, neurosciences and pharmacology, in her view, have accorded natural sciences the credibility to explain the cause of mental disorder as also to treat the same, thereby subsuming the role of the sociological perspective on mental health and disorder. She argues that social processes define and categorize mental disorder, play a significant role in aetilogy of mental disorder and also cast an influence on mental health practice; therefore, the same merits attention. Busfield traces the germination of the sociological perspective on mental health to Durkheim. She also makes a mention of early sociologists, for example Talcott Parsons and Foucault who have contributed to the sociological discourse on mental health. She points out that while the medical paradigm of mental health is largely dominated by genetics and the psychiatric paradigm by that of neuroscience, the sociological paradigm draws attention to the structural factors that impact mental health. She refers to several studies which have revealed the impact of a range of social factors such as economic class, life events, childhood experiences, gender, ethnicity and factors embedded in one's immediate social situation on mental health. Interestingly, she asserts the relevance of labeling theory, which had been rejected by many scholars, by asserting how attitude towards those diagnosed with mental disorder is shaped by the diagnosis given rather than by the individual's actual

mental state. Busfield emphasizes that a sociological approach is essential in appropriately addressing issues related to mental health and disorder particularly in the case of women who are mired in unfavourable social circumstances, therefore this book by Busfield is of particular relevance to the present study. While emphasizing on the relevance of the sociological paradigm, she argues in favour of an integrative approach - that conjugates the mind and the body, the medical and the social- in approaching mental health and disorder in a holistic manner.

Horwitz (2010) holds up the relevance of the sociological approach on mental health and disorder as the same points at social circumstances such as negative life events, persistent stressful situations, demanding social roles, social support and cultural system of a particular society as factors that have the potential to affect mental health. Horwitz also forwards the view that social and cultural influences determine the definitions of and responses to mental health problems. The author makes an important point on how the sociological perspective has raised question on the medicalization of a number of conditions, the increased use of psychotic drugs to deal with mental health problems, and the acclivity to equate emotional suffering with mental disorders that warrant professional help, thereby attempting to transform how mental disorders are perceived and addressed. The sociological perspective brings to light the fact that mental distress may well be a consequence of how a society is structured and organized. Horwitz elaborates on how dimensions of social life such as social integration, stratification, and cultural systems of meanings rather than abnormalities present within the individuals explain the mental distress experienced by people living in any given time and place. Importantly, the author points out that social processes impact the classification of mental disorders as well as the mode of treatment to address the same. The author emphasizes on the impression that social factors make on thoughts, feelings, and behaviors of individuals living in a particular society at a given time, which therefore logicises the claim of the sociologists that elements of one’s social circumstances have a bearing upon one’s mental health and should therefore be factored in while approaching the subject of mental health and disorder.

Rogers and Pilgrim (2010) critique the dogmatic and paternalistic stand of the biological perspective that belittles the import of sociological theorizations on mental disorder. In spite of the tall claims, the biological perspective on mental health fails to account for the array of mental disorders that could not be definitely linked to biological causes. The authors refer to several sociological commentators who have pointed out at technological advancement and vested commercial interests of pharmaceutical companies as the principle reason impelling medicalization and institutionalization of certain diagnostic categories such as post-traumatic stress disorder, depression and eating disorders. Though the sociological perspective is important as it holds up the role of social factors in impacting mental health, nevertheless, the authors point out that the same may tend to leave physical disorders non-problematized. Rogers and Pilgrim reflect on how the mutually oppositional stance of the biological and the sociological perspectives is a manifestation of the mind-body dualism. An important point made by the authors is that contrary to the belief that sociology is a recent commentator on mental health and disorder, sociology has been actively contributing to the domain for the past fifty years or so. Social science, as the authors argue, existed at the beginning of medicine and that some of the early works of social medicine may be regarded as the foundational bedrock of sociology. Further, the authors point out how sociologist and psychologists would collaborate to produce some of the ground-breaking epidemiological work of the 1950s and 1960s .However, overtime discord between the two disciplines emerged especially owing to the involvement of sociologists in the anti-psychiatric movement. The authors make the persistent claim that the sociological perspective on mental health needs to be duly acknowledged as the same dwells on the social causes of mental disorder thereby expanding the theory of aetiology and also provides a competing perspective to the already extant biological and psychological perspectives on mental health and disorder.

2.3.2 Gender and Mental Health

Gender is an important determinant of mental health and the interaction of gender with structural factors is particularly relevant in understanding mental health of women.

The following literatures have been referred to by the present study in order to gauge the factors that impact mental health of women.

Renu Addlakha (2008) advocates in favour of a multidisciplinary approach in addressing mental health. She draws from the interdisciplinary streams of postmodernism, sociology and medical anthropology to deliberate on the manner in which socio-cultural elements interact with mental disorders particularly in the context of women. Gender based role and conduct expectation, she posits, influence psychiatric definition of normal and pathological; therefore, a gender based perspective of mental health and disorder is important. In her view no other single group reflects the impact of social factors such as poverty, illiteracy, unemployment and social disintegration on mental health better than women in whose lives the mentioned factors are particularly pertinent. Addlakha makes some important points in her book which are salient to the present study. For instance she brings to fore the ambiguous position of women in societies like that of India, where the same is revered as a goddess and also viewed as wanton and impure, whose sexuality therefore needs to be bridled by social institutions, both familial as well as institutional. She puts forth the argument that common mental disorders among women are reflective of the resistance of women against the idealized vision of femininity projected by patriarchal society on one hand and the inert desire to approximate the social stereotype on the other. An important point made by Addlakha is about how the process of socialization in Indian society which aims at inculcating patriarchal values of womanhood in the women not only represses their expression but also makes them more vulnerable to mental disorders. She explores stressors related to a woman's role as wife, daughter–in–law, mothers as well as issues like childlessness and motherhood and how these sundry factors influence the mental health of women. This aspect of the book makes it pertinent for the present study. In this book, Addlakha discusses a plethora of cases that highlight the socio-cultural factors that particularly characterize the lives of lower and lower middle class families in urban India which amply reflect the fact that psychopathology among women is quite often a manifestation of underlying crisis of identity, family and marriage. Thus, Addlakha provides an in-depth understanding of the complex connect between women and mental disorder.

Joan Busfield (1996) studies mental health of women from the sociological and the feminist perspective and critiques the claim that mental disorder is essentially a female malady by exposing the politics inherent in the same. She points out at the fact that gender was integrated into the studies on mental disorder only after second wave feminism, prior to which the same was not studied in a systematic manner. She mulls the over-representation of women in patient statistics by disaggregating the data on the basis of age, marital status, social class, ethnicity and historical period to show how these social factors interact with gender to impact mental health. While she does endorse the claim that social factors have the potential to generate mental disorder, she prefers a study of specific structural features pertinent in the lives of men and women and the implication of the same in their respective lives in order to have a nuanced understanding of how social factors impact mental health of men and women. The emphasis here is that women of the underprivileged groups are more vulnerable to mental disorders owing to the structural disadvantages and constraints of their circumstances. She explores gender construction of mental disorders particularly in the context of male and female behavior, as stipulated by social norms, and reflects on how the notion of rationality and autonomy as male characteristics while emotionality and passivity as that of females holds its sway not just over everyday transaction of life but also over psychiatric diagnoses. Busfield draws attention to the fact that mental disorders among women can be studied as socially constructed notion attached to women on account of their perceived biological weakness, and also be explored as a product of social factors that impinge upon the lives of women in a negative way. Busfield explains the prevalence of common mental disorders such as depression, anxiety, anorexia nervosa among women on the basis of the manner in which women are attuned to expressing their emotions, which also explains the prevalence of alcoholism and criminal tendencies among men. The basic point mooted is the differential socialisation of male and female members which is reflected in the manner in which they emote and also in the nature of the mental disorders they commonly experience. Busfield also reflects on the stress induced by specific structural factors in the lives of women and the impact of the same on mental health. Further, she argues

against a monolithic conception of mental disorder and suggests that the term connotes the entire range of mental disorders including the common as well as the severe mental disorders. Through this book Busfield suggests that the relations between gender and mental disorder need in-depth study of how gender interacts with particular structural factors and manifests in particular disorders.

Bhargavi Davar (1999) forwards the view that mental health is a feminist issue as patriarchal ideologies that shape scientific and social disciplines also influence the same. The salience of Davar's work lies in the fact that it covers varied aspects related to women and mental health, thereby offering a comprehensive frame of reference for the study She mulls the prevalence of mental disorders among women and emphasizes that there are more number of women suffering from mental disorders than is projected in studies, as most studies refer to hospital samples rather than community samples. Gender disparity in accessing institutional service accounts for low prevalence of women in institutional statistics. Davar vouches for a sociological perspective on mental health of women as there exists a personal and interpersonal dimension to the same; however, the experiential reality of women's mental disorder is largely ignored by clinical and diagnostic heuristics. She makes the relevant point that common mental disorders are more prevalent among women and have their genesis in the social circumstances of the same than in bio-genetics. She discusses social circumstances, pertinent to the lives of women, which pose as stressors and impact upon their mental health in a negative manner. She also throws light on how women articulate an expression of their mental distress through possession and trancing rituals. The most relevant aspect of this book, to the present study, is Davar's contention that women's mental health be studied from the perspective of distress rather than illness. She substantially hints at the social genesis of women's mental distress thereby providing the substratum to the present study. She argues that illness is a medical construct while distress is rooted in the experiential reality of women and therefore more pertinent in the discourse pertaining to women's mental health. The term mental illness presumes a connect with biological and psychological factors while distress goes beyond the limit defined by psychobiology and uncovers the affective realm underlying the lives and

experiences of women. To substantiate her analysis of mental health practices in India, as constructed within gendered relations, Davar falls back on philosophy of science, psychiatry, psychology and feminism. Davar's book *Mental Health of Indian Women: A Feminist Agenda*, is significant in as much as it brings about a distinction between mental illness and mental distress and how the same occupies centre stage in any understanding of mental health of women. Davar grounds the fact that approaching women's mental health from a distress perspective allows a cognizance of the social aetiology of mental disorder.

Showalter's (1987) traces the history of insanity with particular focus on women. She argues that madness was perceived as a malady prevailing largely among women owing to their biological disposition, a construction shaped and promoted by patriarchal society. Showalter makes the important point that culturally condoned ideas about appropriate female behavior have shaped the definition and treatment of mental disorder among women for 150 years, and have given mental disorder in women specific sexual connotations. In Showalter's account of female malady, as she articulates the idiom, she puts forth the view that mental disorder among women can be viewed as a protest of women against their subjugation and exploitation and that psychiatric diagnosis and treatment is shaped by culture, that is to say that the culturally shaped attitude towards and expectation from women impact psychiatric intervention. She studies insanity across a length of time, from 1830 – 1980, and points out at the increasing number of women in asylum which she attributes to the attitude that society harbours towards women. Showalter deliberates on how women, who were snubbed as irrational, unstable, childlike, and shorn of legal rights and economic opportunities largely constituted the residual categories of society from which much of the asylum population was drawn. Against this backdrop, psychiatry emerged as a social institution of control taking upon itself the responsibility to treat women with mental disorder in conformity with the culturally defined norms of behaviour, conduct and disposition. Further, the conviction that women are prone to mental disorders owing to their reproductive systems was used as a pretext to restrain the participation of women in profession, to deny them political rights and keep them under male control whether in the family or the

state for that matter. Showalter also brings to fore her conviction that hysteria, prevalent among middle class girls of 19th century was largely as a result of the restrictions imposed upon them and the realization of futility shrouding their lives. Showalter holds forth her view that women remain largely excluded from public life, which is the space where action takes place, therefore, they have to explore the scope for self-realization through personal relationships. Thus, women become increasingly dependent on their inner life which explains their greater susceptibility to mental disorders such as depression and nervous breakdown. In her book, Showalter decries the manner in which the medical system monopolized by the males reinforces the powerlessness of women by limiting them within the confines of mental institutions and repressing their voice of distress. She therefore makes an earnest suggestion that female psychiatrists be trained who, she posits, would be sensitive and empathetic towards the female plight. She also argues in favour of self-help organizations to offer non-medical support; these efforts, in her view, would bring about a political shift from masculine hegemony over institutional management and intervention to a more woman centric ethos of care.

Chesler (1972) integrates the perspective of a psychological researcher, theoretician, clinician, and that of a literary and philosophical person to articulate her discourse on women and madness. She holds forth the view that by the end of 19th century the culturally promulgated image of madness was principally that of women. Accounting for the fact that more women than men feature as psychiatric patients, Chesler indicates at the psychological constitution of the females that is shaped by an oppressive patriarchal culture. She opines that women are more liable to be labeled as mentally disordered than are men, even if the latter displays disturbed behavior. This is indicative of the societal attitude that views women as inherently disposed towards madness. One of the very important arguments forwarded by Chesler is that non-adherence with the socially stipulated roles assigned to females (as also to the males) is a social transgression that leads to females (also males) being labeled as mad. The stress is on conformity with sex roles, a violation of which is perceived as madness. Thus, Chesler rubs in the idea that the label of mentally disordered is a social tool to ensure that male and female members adopt the socially condoned sex roles. However, the women stand

on precarious grounds for they are labeled disordered not only if they violate sex role expectations but also if they conform to the devalued female role. Chesler drives in the point that the role of the females is devalued by society and commonly considered to incline towards mental disorder, thus, putting the women at a doubly disadvantageous position. Chesler grounds well the fact that attributes of positive mental health such as rationality are commonly associated with the males while negative traits like that of irrationality are typically linked with the women. Though critical of the psychological perspective on mental health, Chesler does not quite toe the line delineated by the anti-psychiatrists. Chesler consciously averts romanticizing mental disorder among women as an articulation of protest or a revolt of the women against the patriarchal atrocities. Rather, Chesler infers that mental disorder among women is indicative of the deprivation of the means to protest and assert feminine selfhood. One therefore, as asserted by Chesler, should view mental disorder among women as an expression of help by women who find themselves culturally devalued and politically restrained. Help seeking behavior, argues Chesler, is however consistent with the socially conceived helpless and dependent feminine nature.

2. 3.3 Stress and Stressors

The core argument on which the present study hinges is that several aspects of women's social circumstance pose as stressors in their lives and impact their mental health. To substantiate the argument references have been drawn from the following literatures.

Selye (1950) is the pioneer of research on stress who puts forward the view that the body adapts to environmental stressors through a biological pattern in order that homeostasis or internal balance is maintained. Selye conceives of the flight or fight response, which is the body's inherent impulse towards retaining homeostasis. Hormonal system of the body responds to externally induced stress so as to restore the balance of the system as early as possible, a process that Selye terms as general adaptation syndrome. However, the body's ability to respond effectively to stressful situations

wears out over time particularly if the exposure to stressor is protracted. The general adaptation syndrome, as postulated by Selye, comprises of three phases which reflect the ways in which the body responds to stress:

A. Alarm stage which is the first phase of a body's response to stress situation. At this initial stage the body perceives the external stressor as a threat or danger which calls for the body's immediate reaction in terms of fight or flight. At this juncture stress hormones such as adrenaline, nor-adrenaline and cortisol are released which enable the body to perform feats that it is not able to under normal circumstances.

B. Resistance stage is the second phase of combat against external stressors. Having responded to the stressor intensely in order to eliminate the threat and restore equilibrium, the body's defenses are likely to become weaker as energy is required to repair damaged muscle tissues and lower the production of stress hormones. At this stage, that is the subsequent stage of stress response following the flight or fight stage, the body remains resistive to the impact of external threat particularly if the same persists in the external milieu of the same, though not as aggressively as it did in the first stage.

C. Exhaustion stage is the culminating phase of a body's struggle against stressful situations. The stress having persisted over time takes a toll on the body's reserve of energy. The body's ability to counter the impact of stress is debilitated as the same is sapped of its adaptive energy after prolonged exposure to stressors. According to Selye, the body is burnt out at this stage and becomes vulnerable to illness. Selye's stress theory is a frame of understanding that suggests how persistent exposure to external stressors can lead to mental disorders.

Davar (1999) emphasizes that women's mental health should be studied from the perspective of distress rather than that of illness as common mental disorders prevalent

among women have their genesis in women's social circumstances and not necessarily related to biological causes. Davar mulls on several socio-economic factors that pose as stressors in the lives of women. Marriage, opines Davar is a stressful aspect particularly for women and often is the cause of much distress for them. Married women and single women, as posited by Davar experience greater distress as compared to married men and single men respectively. Further, Davar reflects on the fact that divorce, separation and widowhood cause greater distress to women than to men. The same is reflective of social prejudice against the single, divorced, separated and widowed women which enhances the distress of such women. Mental distress among women is highest in their reproductive years which somewhat decreases in their old age, as per the data revealed by some studies; nevertheless, widowhood, which often occurs in old age definitely bears a negative impact on mental health of women as Davar sieves from relevant studies. The important point made here is that in spite of the supposition forwarded by some studies that mental distress occurs less among old women, old age is characterized by certain vulnerabilities such as widowhood which act as stressors impacting mental health. Davar speculates on the impact of family structure on mental health. While the positive impact of joint family on mental health has been making the rounds in popular discourse, some literatures have also grounded the negative impact of the same on mental health. Joint family structure often fans conflict and promotes oppression. Moreover, the support purported by joint family often fails to materialize in reality, with the consequence being that most of the mentally disordered individuals are abandoned by their family members rather than being supported by them. Davar also reflects upon violence against women as a stressor that imperils their mental health. Violence against women is rooted in the unequal structure of the society which promotes the interest of the male members and domination of female members. Violence against women deals a blow at both their physical and mental health. A range of mental disorders such as shock, anxiety, fear, humiliation and post-traumatic stress disorder are common fall outs of violence against women. Violence is often an expression of male power that seeks to keep women reined within socially stipulated limits. Violence among men is hardly viewed as pathological; rather the same is justified as necessary to control the untempered impulses of women. Violence is often employed as an instrument of control

which is rampant in societies that have preserved the unrelenting patriarchal ideologies and have resisted an egalitarian ethos. Further, Davar points up the fact that poverty exposes women to many vulnerabilities of life and is one of the major stressors that impresses heavily upon mental health of women. Therefore, the homeless women, sex workers, household maids experience greater distress in their lives.

Busfield (1996) highlights the fact that mental disorders are more common in the lower social classes where the distress experienced owing to difficult and stressful life circumstances is more. She emphasizes that distress emanating from inimical social condition is more among those located at the bottom of the social structure, an argument that indicates at the vulnerability of women whose inferior social position exposes them to more hostilities of life and negatively bears upon their mental health. Busfield also mulls on the differential response of males and females to the stressors of life. The process of socialization attunes the women to internalize their emotions while the males are encouraged to externalize theirs, the same accounts for the fact that women are prone to common mental disorders like depression, anxiety disorders etc. while the men given in to alcoholism, criminal behavior etc. Further, Busfield draws from scholars such as Jackson (1962) to suggest that the women have relatively limited scope for self-actualization. However owing to their tendency to internalize their emotions, they blame themselves for their low achievement and thwarted aspirations, which, enhances distress and therefore imperils their mental health. Busfield brings to fore the diversity of events that may be considered as stressors, while some scholars focus on everyday life events others dwell upon bigger and more impactful events as potential stressors threatening mental health. However, the core point is that stress experienced is dependent on personal resilience and therefore stressful events cannot be generalized, rather ought to be studied in the context of individual response to the same. Busfield strongly makes the point that women experience more distress owing to certain aspects of their social circumstances such as absence of strong social support, strong emotional involvement with others and the burden of care heaped on them; therefore, they are at greater risk of developing mental disorders.

Some of the social stressors specifically studied include marriage, economic status, religion and violence against women. The ideas consolidating the claim have been largely drawn from the following literatures:

Gove (1972) attributes the higher prevalence of mental disorder among women to the role that they have to perform in their marital lives. Gove reflects on how women of certain categories display greater tendency of developing mental disorders, for instance the author refers to literature relevant to the domain which reveal how married women have conspicuously higher rates of mental illness than married men. Further having drawn from studies conducted by scholars prior to him, Gove reflects on how married women show greater propensity towards mental disorders than those in other categories. Gove therefore categorically aims at the marital roles of women which are largely unfulfilling, strenuous and frustrating and cast a baleful impact on their mental health. Gove suggests that, firstly a married woman's structural base is relatively frailer than that of a man. Secondly, the major role assigned to women is that of maintaining the house. However, the same has the potential to cause frustration to women as it fails to address the aspirations of the same. Thirdly the role of a housewife, though onerous, is rather unstructured and invisible. Fourthly even when married women work, they are generally assigned less skilled routine jobs with lower remuneration than their male counterparts which therefore becomes the cause of much consternation that they experience. Finally, the expectations confronting women are unclear and diffuse. Gove elaborates on the negative aspects of marital roles to explain the prevalence of mental disorder among married women. The core point that is rubbed in here is that marriage poses itself as a stressor in the lives of women and may impact their mental health.

Murali and Oyebode (2004) study the direct and indirect effects of poverty in causing emotional, behavioural and psychiatric problems. The crux of the argument posited by the authors is that socio-economic status is a critical determinant of mental health, a fact amply borne out by the evidence that members of deprived communities suffer more from poor health and higher mortality. Poverty portends great threat to health, whether physical or mental. The poor are commonly exposed to unfavourable

social environment where several threats loom large; for instance, they may find themselves trapped in stressful professions where they may be compelled to perform unrewarding and dehumanizing work, and they may not be able to negotiate their way out of a life of deprivation owing to which the women may find themselves with negligible social support. The fact that poverty imperils health, mental and physical, has dominated the discourse on public health for long. Drawing from the canon of literature available on the relation between poverty and health, the authors dwell on how members of the lowest social groups are more likely to suffer negative effects of risky health behaviours than those placed in economically advantaged position. The impact of poverty is not limited to infectious diseases alone; rather the same is evident in psychiatric conditions which abound in economically deprived communities of the society. The authors emphasize that money does not ensure mental health, nor a lack of it necessarily paves the path to mental disorders. Nevertheless, the fact remains that poverty can be a determining factor of mental health and can also be caused by mental disorder and the associated disabilities it entails.

Perry (1996) refers to the mental hygiene studies which first postulated the inverse relationship between economic class and mental disorders, though the same has been endorsed by subsequent studies as well. Several studies have expounded the connection between economic class and mental disorder either in terms of downward drift that forwards the argument that decline in social status of individuals occurs due to mental disorders they suffer from, or in terms of the theory of social causation that asserts the role of psychosocial stressors in causing mental disorders. Perry studies an array of factors that potentiate the occurrence of mental disorders among those that are confronted with such situations. Perry dwells upon the high prevalence of mental disorders among women which can be traced to the fact that majority of the people trapped in economically disadvantaged situations are women. Perry points out the vulnerabilities of women such as unemployment, engagement in low-paying jobs which trap them in the vicious circle of poverty etc. Further, the author reflects on the plight of single mothers, who without financial assistance from former partners are confronted with economic constraints and in course of time may develop symptoms of common

mental disorders like depression. Drawing from studies conducted by other scholars, Perry reflects on how exposure to chronic stressors such as inadequate housing, having to raise children in conditions of persistent financial paucity, threats to personal safety and little social support are characteristic features of low income women and are particularly detrimental to their psychological health. Further, the stereotyped conception of women as powerless and dependent on male support, explains Perry, becomes cause of greater distress to women.

Klingorova and Havelick (2015) study how religion, its norms, traditions and the overall ideology it promotes, brings about gender inequality in society. Employing an exploratory quantitative analysis, the authors conduct a study on how religion impacts gender inequality in social, economic and political spheres. In order to reveal the role of religion in precipitating gender inequality, the study focuses attention on three categories of state, *viz.*

i. states with lowest level of gender inequality (members of such states have no religious affiliations)
ii. states with average level of gender inequality (members of such states are affiliated to liberal religions like Christianity and Buddhism)
iii. states with highest level of gender inequality (members of such states are affiliated to orthodox religions like Islam and Hinduism).

The authors mull on how religion in conjunction with factors such as cultural legacies, historical development, and geographic location plays a decisive role in shaping the structure of societies. The authors further, probe into how religion and culture share a reciprocal relation, where each casts influence on the other and influence of each domain shapes the other. Referring to relevant studies, Klingorova and Havelick make the point that gender roles are constructed through religion, culture, life-style and socialisation process. All world religions, the authors argue, are dominated by the male and reflect patriarchal values. The role of a woman in religious ceremonies is subservient to those of the males. The authors draw attention to the fact that the status of women as reflected in religious texts is indicative of the

actual status women occupy in society. In the history of religions, as pointed out by the authors, the voice of women is hardly heard. Though religious texts vouch for respect of women especially in their role as mothers and wives, they do not however suggest an elevation of women's social status at par with the male members. Nevertheless whatsoever ideas of women's equality are propagated by religion, the same stands in disjunction with what prevails in everyday life. The authors are however cognizant of the heterogeneity of universal categories such as Islam and Hinduism, therefore, they suggest that generalization on the influence of religion may be avoided and contextual differences may be factored in.

Mann et al. (2004) point out at the connection between self-esteem and mental health, where the former is projected as an indicator of the latter. Positive self-esteem is a protective factor against physical and mental disorders while negative self-esteem is a risk factor for the same, as posited by the authors. The authors propose the idea that poor self-esteem may cause a range of mental disorders and social problems, which may either be in the category of internalizing problems (e.g. depression, suicidal tendencies, eating disorders and anxiety) or that of externalizing problems (e.g. violence and substance abuse). Mann et al. assert how self-esteem is critical to mental health and ought to be duly acknowledged in academic, clinical and policy level discourse on the same. The manner in which individuals perceive themselves, their attributes and qualities is understood as self-concept while self-esteem is the evaluative and affective aspect of the self-concept. Positive self-esteem, the authors opine acts as a buffer against inimical influences and as a protective factor that cultivates mental health and positive social behavior. The authors assert that positive self-esteem conduces healthy functioning of individuals manifested in attributes such as drive for achievements and success, sense of satisfaction with life, and ability to cope with ailments. Mann et al. forward the view that a plethora of mental disorders and social problems, such as depression, anorexia nervosa, bulimia, anxiety, violence, substance abuse and high-risk behaviors often are off-shoots of negative self-esteem. Thus the point driven home by the authors is that self-esteem is a vital determinant of physical and mental health and

therefore warrants due attention, especially in endeavours related to health promotion, more so mental health promotion.

Jordan, Campbell, and Follingstad (2010) in their review article explore literature that discusses the impact of violence on mental health. Violence against women is an important determinant of mental health, the authors posit, and that most forms of non-organic mental distress stem from violence encountered by women in their lives. Drawing from the literature considered for the study, the authors emphasize that violence against women is not a monolith entity and may assume any of the forms, *viz*. physical assault, sexual assault, stalking, and psychological aggression. The mental disorders that occur owing to violence against women include anxiety post-traumatic stress disorder (a subtype of anxiety disorder), depression and substance abuse. The authors make an important point about the inadequacy of field research on the impact of violence on the mental health of women which thwarts any scientific exploration of the same.

Warshaw et al. (2009) bring to fore the fact that intimate partner violence (IPV) lends a substantial blow to mental health, often resulting in mental disorders such as depression and posttraumatic stress disorder. According to the authors, mental health symptoms experienced by those exposed to IPV is mediated by factors such as the individuals innate strength, duration and severity of abuse, exposure to other lifetime trauma, resources at their disposal and social support they receive. While dwelling upon the impact of IPV on mental health, the authors also deliberate upon how women suffering from mental disorders are vulnerable to abuse and how the same can precipitate post-traumatic stress disorder among the same. Stigma associated with mental disorders provides abusers with the latitude to manipulate their partners, gain an undue advantage in divorce cases and custody battles and shame them for their debilitated state. The authors reflect on how advanced research in the fields of traumatic stress, child development, genetics, and neuroscience have opened new vistas for understanding the manner in which exposure to violence impacts mental health and life trajectories, as well as the impact of adult traumatic events on physical and mental

health. These emerging cannon of knowledge, as suggested by the authors, offers a substantial framework for comprehending the spectrum of mental health issues experienced by the women who have encountered IPV in their lives.

Campbell (2002) studies mental and physical health sequelae of violence against women. Drawing from studies conducted by other researchers, the author mulls on the various symptoms that are manifested by women post exposure to violence, including the detrimental post natal outcome of violence that is encountered by pregnant women. The author vouches for incorporation of assessment and intervention mechanisms in health care settings, as the battered women are more likely to report to hospitals first than to criminal justice systems. If health care settings are attuned to identifying abuse then these settings can offer timely support and intervention to the women that present themselves therein. Campbell asserts that the physical and mental-health offshoot of violence should concern both the researcher as well as healthcare practitioners. Violence against women leads to a range of symptoms such as smoking, poor nutrition, substance abuse, and stress. However, any attempt to correct the symptoms without attempting to correct the cause of the same would prove to be a futile endeavor. Therefore interventions ought to address not just the symptoms but also the underlying cause, i.e. violence and abuse against women. The author opines that research, particularly in developing nations, should be conducted after designing intervention plans that ascertain safety and better mental and physical health for abused women.

Wasco (2007) urges in his paper that instead of blindly approaching the cases of raped women from the perspective of trauma response model, the subjective experience of the same must be taken on board. The author suggests that the trauma response model may deal with threat to life and experience of horror of the victims; however, the same may fail to take into cognizance the social and cultural norms that may justify violence against women and offer clemency to the perpetrators. Wasco puts across his concern that social attitude towards the rape victim may fan self-blaming tendencies among the same and compound the harm done to the victim by rape. The author argues that research conducted in the present domain must bring into consideration the trauma of

rape along with the subsequent social attitude towards the rape victim to make holistic assessment of the harm caused by rape. The cultural context in which the rape victim is located and the social status of the victim are important mediators that define the experience and suffering of the rape victims and consequently the mental health implication of the same. Such an endeavor, the author opines, would be able to record the experience of rape victims across social classes and cultural contexts. Though the article deals primarily with women who have been subjected to rape, the author suggests that his arguments may be reasonably applied to women who have been victims of other traumatic episodes.

Riberio et al. (2009) review epidemiological literature on the impact of violence on mental health of women especially in low and middle income countries (LAMIC). The literature reviewed by the authors deals with vulnerable groups such as children and adolescents, women, and general population. In this review, the authors bring out how exposure to violence significantly affects mental health of children and adolescents, particularly when other disadvantageous circumstances such as poverty and maternal CMD prevail. Most commonly children and adolescents exposed to violence manifest externalizing problems, which often leads to functional debilities, violent behavior and other mental disorders later in life. The author draws from several studies to point out how women living in low and middle-income countries are more vulnerable to victimization, whether at home or at their workplace, which is largely owing to the patriarchal set-ups of these countries that promote gender inequality. The authors reflect on how exposure of women to violence causes common mental disorders and how suffering violence in sensitive phases of life such as pregnancy can lead to health hazards of both the mother and child. The authors note that since maternal CMD (common mental disorders) can negatively impact mental health of children, violence against women has a strong implication for mental health outcomes among children and adolescents. Importantly, the authors in assessing the vulnerability of the general population to traumatic events point out at the gender disparity in exposure to traumatic events. While the women have been observed as being victims of violent events perpetrated by family members and/or intimate partners, men are more vulnerable to

traumatic events that generally take place in the community. The authors drive home the point that though the men and women experience traumatic events, it is the women who are more susceptible to mental disorders resulting from exposure to violence. The moot point here is that women of LAMIC are relatively more vulnerable to violence and that the same casts a definitive influence on their mental health. The authors indicate at the cultural and social factors of LAMIC that endorse violence either as a tool of control or as a mechanism for males to retain their power. Therefore, the authors suggest that both victims as well as perpetrators of violence should be roped into programmes aiming at prevention of violence against women.

Garcia-Moreno and Stockl (2013) reflect on violence against women as a serious social and public health issue which not only impacts the health of women and their children but also is a gross violation of women’s human rights. The authors put forward their view that the common forms of violence that take place across the globe includes intimate partner violence, sexual abuse perpetrated by non-intimate partners, human trafficking, female genital mutilation and sexual violence that occur in conflict situations. The authors make the point that women are vulnerable to all forms of violence, particularly intimate partner violence. Intimate partner violence wreaks havoc in the lives of women particularly for the groups of women who exhibit greater vulnerability such as pregnant women, adolescent girls, and women with disabilities or those indulging in substance abuse. The authors provide an insight into the health outcomes of violence; physical health outcomes including fatal outcomes, such as homicide, suicide and maternal mortality to nonfatal health consequences such as physical and chronic health problems, mental health and sexual and reproductive health problems. By highlighting the physical and mental health consequences of violence against women, the authors root the rationale for implementing policies and strategies towards prevention as well as appropriate redressal of violence against women in the health sector and to articulate the preventive strategies from the perspective of women’s rights.

2. 3.4 Labeling and Stigma

A discussion on labeling and stigma is very much pertinent to mental health discourse. The present study touches upon the topic of labeling and its consequence on mental health and also probes into stigma that the women with mental disorders live with. The mentioned aspects of the study have been informed by the literatures summarized here.

Scheff (1966) is the first to have postulated that mental disorder is a label attached to individuals who deviate from normative behavior. Being mentally disordered, to Scheff, is a status conferred on certain individuals by others, whether lay or professional, in their social environment. Individuals who violate fundamental rules of social interactions are viewed as deviants and violation of these rules of everyday life, which Scheff refers to as residual deviance, triggers the process of labeling. Scheff's main argument is that being labeled as mentally disordered, the concerned individual plays out the role of the mad. The labeled internalizes traits expected of a mad person and manifests the same through her/his behavior. Scheff contends that institutionalization further stabilizes the identity of those individuals that avail themselves of psychiatric treatment and/or are admitted in institutions that offer treatment for mental disorder. The central argument posited by Scheff is that the label of mad attached to those perceived as deviating from the standard social stipulations on conduct indeed drives one to eventually become mentally disordered. For the present research, the biggest take away from Scheff is the indication at social forces which impinge upon the personal experience of mental disorder. Scheff explains how the social characteristics of the labeled and the social circumstances in which human interaction takes place determines the process of labeling, thus driving home the point that the process of labeling rests more on social dynamics that on the symptoms of pathology.

Link and Phelan (2010) point out the criticism of Scheff's theory offered by Walter Gove who argued that social response towards the mentally disordered is influenced by the symptoms manifested by the same rather than by any label attached to the mentally

disordered. He proffered the argument that labeling does not bring about further deviant behavior; rather the labeling of an individual is triggered by the deviant behavior the same manifests. Against this backdrop modified labeling theory was proposed by Link and his colleagues who, instead of deliberating on whether or not labeling is a direct cause of mental disorder focused on the process through which labeling and stigma thwarts life opportunities of people with mental disorders, negatively impacting their scope for employment, social status, and self-esteem. These disadvantages, it is argued, puts those that are thus labeled at greater risk of prolongation or reoccurrence of mental illness. The authors summarize the postulation of the modified labeling theory on the manner in which labeling and stigma function to jeopardize the labeled. It is suggested that people develop lay conception of mental disorders and those that are afflicted by such disorders through the process of socialization. This conception is personally relevant for those suffering from mental disorder as the same may lead to devaluation and discrimination of such individuals. The fear of being rejected may lead those who are suffering from mental disorders, particularly, those that have been hospitalized, to act less confidently and more defensively and may also impel them to avoid potentially threatening contact altogether, thus, resulting in an overall compromised quality of life. An important point made by Link and Phelan is the integration of concepts like stigma, labeling, stereotyping, and discrimination into an integrated whole. Stigma is a process, as formulated by Link and Phelan, which entails the following aspects. Firstly, people are differentiated and labeled on the basis of difference from the regular and the normative. Secondly, the prevalent cultural beliefs associate the labeled with negative stereotypes. Thirdly, the labeled are marked aside from the mainstream of the society so as to affect a categorical distinction between ‘us’ and ‘them’. Finally the labeled, thus demarcated and denigrated, experience status loss and discrimination that impedes their life opportunities and hampers the overall quality of their life. The authors make the point that the process of stigmatisation is affected by access to social, economic and political power, that impacts the identification of differentness, construction of stereotypes, segregation of the labeled persons into categories and exertion of social disapproval, rejection, exclusion and discrimination. Thus, it is suggested that the process of stigmatization is wholly affected by the power situation in which the

individual is located. The authors refer to their own works documented in the past which have outlined the three functions of stigmatization, *viz.* exploitation and domination, norms enforcement and disease avoidance which hints at the socio-political undercurrent of the process.

Goffman (1963) has extensively dealt with the subject of stigma and the stigmatized, who as the author opines are denied social acceptance and suffer from a botched social identity. Stigma discredits one's identity and indicates at moral flaws; the social expectation from the stigmatized, therefore, is low. The stigmatized in Goffman's formulation are not only those that suffer from mentally disorders but include a wide range including the physically deformed drug addicts, prostitutes, etc. Goffman outlines three types of stigma *viz.* stigma of character traits, physical stigma, and stigma of group identity. Stigma of character traits indicate at weaknesses of human nature, while physical stigma is indicative of physical deformities. Stigma of group identity is the stigma that is derived from one's membership to a particular race or ethnic group. Whatever form of stigma an individual suffers from, the same impedes her/his social interaction and isolates her/him from the normal (a term used by Goffman) members of the society. Goffman deliberates on the response mechanism adopted by the stigmatized, who may choose to maintain secrecy about their trait that calls for sanction or camouflage the same. Further, stigma may be used as an excuse for failure in ventures of life or one may choose to withdraw, the latter, however, may precipitate further isolation and mental agony. Goffman elaborates on stigma symbols which he suggests are markers of stigmatized individuals. He forwards the view that stigma symbols are information modulators about the stigmatized individuals. Those stigmatized may use symbols as disidentifiers in order to pass as normal, however, the same would require great caution on the part of the same so that the telltale signs of stigma are not given away. The stigmatized, as argued by Goffman, may also purposefully disclose their discrediting attributes in order to manage the resulting tension and not to let their stigma loom large in social interactions. Goffman offers a set of rules that the stigmatized may adopt in negotiating with the normal members of the society in order to ease out the tension in their social interaction. However, Goffman forwards the view that the normal

members would never be able to fathom the travail of the stigmatized and no matter how much the latter attempts to mainstream herself/ himself , she/he can only achieve “phantom acceptance…phantom normality” (1963, 148). The author makes the point that normalcy and stigma are part of a bipolar social process and that there exists no rigid distinction between them, so much so that individual members of a society may take up both of these roles. Goffman ventures his ideas on deviance and posits his view that a range of individuals can be perceived as deviants and is not limited to specific malingerers. Deviants may well include rebels who voluntarily choose not to affiliate themselves with social norms or may be members of groups who collectively flout established order and norms. Further, that marginal deviants may also exist is grounded by Goffman. Moreover, suggests Goffman, some forms of deviance may well be within the socially formulated limits of tolerance while some other forms may be totally forbidden. Thus, he makes the point that deviance is too vast and confounding a subject to be dealt with in a simplistic manner. Winding up his treatise, Goffman suggests that all members of the society are equally vulnerable to stigmatization, should they deviate from the socially condoned standards and norms. Nevertheless certain individuals enjoy group defenses against stigmatization which act as buffer for them, while many other groups (like that of women) lack defenses and are, therefore, rendered particularly vulnerable to the process of stigmatization.

2. 3.5 Possession and Trancing as Metaphoric Expressions of Distress

The thesis builds itself around the idea that social circumstances prevailing upon women’s lives make them susceptible to mental distress and that the pent up distress manifests in the form of common mental disorders. The accumulated burden of distress is also expressed by women metaphorically through episodes of possession and trancing. Possession and trancing are studied as idioms of distress, an argument that has been nourished by some literatures presented hereunder.

Nichter (2010) explains how idiom or expression of innate distress is shaped by culture. The author argues that diagnosis and treatment systems do not develop in

isolation from the cultural matrix which lends a substantial influence on the manner in which distress is experienced and expressed. Therefore, suggests Nichter, there ought to be a fit between forms of distress nested in specific cultural context and mode of diagnosis and treatment. The author feels that the manner in which distress is expressed in culturally salient ways merits exploration. He posits the idea that idioms of distress are adaptive responses in situations where other modes of expression fail to articulate an uninhibited ventilation of inert distress or to provide adequate coping mechanism. Nichter explains idioms of distress as socially and culturally relevant means of ventilating distress in local worlds. Underlying these idioms are past traumatic episodes or stressors that characterize the present life situation of concerned individuals. According to the author idioms of distress are reflective of internal stress, whether mild or profound, that impede an individual's productive functioning in society. In some cases, suggests Nichter, idioms of distress are culturally and interpersonally effective strategies of coping with distress. Nichter expounds the import of the term cultural idioms of distress as indicative of culturally sanctioned mechanisms of articulating distress. Further, that the term reflects the manner in which shared beliefs of a specific locale shape the experience and expression of distress is bared forth by the author. Nichter, in his article argues that idioms of distress acquire relevance and meaning in their specific cultural contexts. To the author idioms of distress are largely meaningful, practical and most importantly non-stigmatized means of ventilating inert distress.

Borguignon (2004) explores the subject of possession trance as a psychodynamic response to powerlessness, exploited largely by the disempowered to gratify wishes that remain unrealized in their lives. To Bourguignon, possession trance is at the same time an idiom of distress and a veiled effort at self-assertion. The author brings to fore how the phenomenon of possession trance is commonly observed among women, which she attributes to their subordinated status in social scheme of affairs. Possession trance is an endeavor by the women to serve their latent interests which however, they are not able to fulfill in their real life circumstances. Possession trance is a culturally acceptable phenomenon; therefore the same becomes an acceptable means of negotiating power

and social status as also a mechanism for uninhibited expression of urges and conflicts latent in women.

Lewis (1966) assumes a functionalist perspective in his exploration of spirit possession, which he perceives as a social protest articulated by the women in a male dominated society to express their discontent and frustrations. Lewis argues that spirit possession is a socially accepted practice; therefore, the possessed is not castigated for the contavenous behavior. While the women remain largely blameless the cause for errant behavior is attributed to the possessing spirit, thus Lewis suggests spirit possession as a thinly disguised protest movement against the males. Like Bourguignon, Lewis too expounds the predominance of women in phenomenon of possession as linked to their exclusion from power circuits of society. Lewis's engagement with the query regarding the category of people that are most vulnerable to spirit possession leads him to hypothesize a connection between spirit possession, religion and social therapy. In most societies, the males hold sway at the expense of the females. The deprivation and peripheral status that the women are thus accorded creates tensions between the two sexes. Lewis, therefore, forwards this view that spirit possession in its essence is a war between sexes in which women get to exercise metaphoric power over the men, who in real life situation subjugate them. Drawing from spirit possession experiences of a number of exotic societies, Lewis avers that traditionally male dominated societies where patriarchal values are imposing and women are expulsed from active participation in social, political, religious activities and not appropriately protected by legal system witness the phenomenon of spirit possession more than egalitarian societies.

Wilson (1967) is of the view that spirit possession is a phenomenon experienced especially by married women, therefore the configuration of the lives of married women merit attention. He therefore seeks attention to the status of wife and the role women are expected to perform in such capacity in explaining the propensity of women towards spirit possession. Wilson contests Lewis's view that spirit possession is reflective of tension between the two sexes, rather locates the same in the competition between

women. In conjugal situations women enter into competitive roles with other women in the husband's community. Married women derive their status and identity from their husbands which may result in status ambiguity. In this context Wilson asserts that through the phenomenon of spirit possession, women resolve the ambiguity of their roles and status in their marital situation. Wilson makes the categorical point that spirit possession is a form of rite de passage whereby social identity may be negotiated and social status asserted. Further Wilson makes it clear that in societies where spirit possession is not professionally practiced, spirit possession is largely employed to re-affirm or redefine marital and situational status. In societies where possession is an institutionalized practice, women are able to ascend to the status of shamans, priestesses and enjoy the privileges thereof. Wilson is of the opinion that the explanation of spirit possession as a means to negotiate status and define identity and as occurring in situations where individual's status is shrouded in ambiguity is a sound sociological conceptualisation of spirit possession than that suggested by Lewis.

Budden (2003) makes a comparative study of two prominent psychoanalytic anthropologists *viz.* Spiro and Obeysekere to study divergent views of the psychological nature of pathological and religious experience. While's Spiro's postulation is of little relevance to the present study, the article by Budden is referred to owing to the views of Obeyesekere on trance possession documented therein. Obeyesekere, as Budden suggests draws attention to the cultural factors that condition dissociative possession. Budden recalls Obeyesekere's book, *Medusa's Hair* (1981) where the latter explains how personal and public symbols from the cultural repository are manifested in symptoms identified with dissociative possession. With reference to the Sinhalese women at the Kataragama cult center in Sri Lanka, Obeyesekere explains how experiences of spirit possession among women have their genesis in traumatic episodes of their lives. However what Obeyeysekere emphasizes upon, as Budden informs us, is how at Kataragama the women fall upon cultural knowledge explaining their conditions and thus transform the symptoms of their afflictions into symbols that are personally as well as socially significant. Budden summarizes Obeyesekere's argument about how in trance possession experiences inert tensions of women are externalized while symbols

of divine favour are internalized in a manner that is personally salient. This transformation of symptoms to symbols entails a process of subjectification in which objectified cultural imagery of divine interaction are personalised on the basis of intra-psychic experiences. The vital point in Obeyesekere's postulation is that in this process, dissociative behavior that could have otherwise been shunned as pathological gains social approval as sanctioned religious experiences. Budden in his article conveys Obeyesekere's emphatic claim that his formulations do take a contentious stand with what he terms as pathological model of culture relied upon by proponents of traditional psychoanalytic perspective, who would view these experiences as pathological. However the incorporation of culture lends a new dimension to the study of dissociative possession, one that views the same as cathartic and therapeutic rather than pathological.

References

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

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

Bhattacharjee, D. et al. (2011). Sociological Understanding of Psychiatric Illness: An Appraisal. *Delhi Psychiatry Journal*, 14 (1): 54-62.

Blumer, H. (1962). Society as symbolic interaction. In Rose, A.M., editor, *Human Behavior and Social Processes,* pages 179–92, Houghton Mifflin Co., Boston.

Bourguignon, Erika. (2004). Suffering and Healing, Subordination and Power: Women and Possession Trance. *Ethos* , 32(4): 557-574.

Boyd, K.M. (2000). Disease, illness, sickness, health, healing and wholeness: exploring some elusive concepts. *Medical Humanities,* 26:9-17.

Budden, A. (2003). Pathologizing Possession: An Essay on Mind, Self, and Experience in Dissociation. *Anthropology of Consciousness,* 14 (2):27-59.

Busfield, J. (1988). Mental illness as social product or social construct: a contradiction in feminists' arguments? *Sociology of Health & Illness*, 10 (4): 521-542.

_______. (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.

Campbell, Jacquelyn C. (2002). Health consequences of intimate partner violence. *The Lancet***,** 359(9314): 1331 – 1336.

Carter, M.J. and Fuller, C. (2015). Symbolic interactionism. *Sociopedia.isa.* Retrieved on 22 Feb. 2016 from http://www.sagepub.net/isa/resources/pdf/Symbolic%20interactionism.pdf

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

Cooley, C.H. (1902). *Human Nature and Social Order*. Scribner’s, New York.

___________. (1909). *Social Organization: A study of the larger mind*. Scribner’s, 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.

Durkheim, E. (1897). *Suicide: A study in sociology*. The Free Press, New York.

Garcia-Moreno, C. and Stockl, H. (2013). Violence against Women, Its Prevalence and Health Consequences. In García-Moreno C. and Riecher-Rössler, A., editors, *Violence against Women and Mental Health,* pages 1-11, Karger, Basel. Retrieved on 04 Apr. 2016 from https://www.karger.com/Article/Abstract/343777

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Simon & Schuster Inc., New York.

Gove, Walter R. (1972). The Relationship Between Sex Roles, Marital Status, and Mental Illness. *Social Forces*, 51 (1): 34-44.

Gove, Walter R. and. Tudor, Jeannette F. (1973). Adult Sex Roles and Mental Illness. *The American Journal of Sociology*, 78(4): 812-835.

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.

Jordan, C.E. et al. (2010). Violence and women's mental health: the impact of physical, sexual, and psychological aggression. *Annual Review of Clinical Psychology*, 6: 607-628.

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

Klingorova, K., and Havlicek, T. (2015). Religion and gender inequality: The status of women in the societies of world religions. *Moravian Geographical Reports*, 23(2): 2-11.

Lewis, I.M. (1966). Spirit Possession and Deprivation Cults. *Man, New Series*, 1(3): 307-329.

Link, Bruce G. (1989). A Modified Labeling Theory Approach to Mental Disorders: An Empirical Assessment. *American Sociological Review*, 54(3): 400-423.

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.

Lyon, B. (2012). Stress, Coping and Health: A conceptual overview. In Rice, Virgina Hill, editor, *Handbook of Stress, Coping, and Health: Implications for Nursing Research, Theory, and Practice*, pages 2-20, Sage Publcations Inc., Thousand Oaks.

Mann, M. et al. (2004). Self-esteem in a broad-spectrum approach for mental health promotion. *Health Education Research,* 19(4), 357-372.

Mead, G.H. (1934). *Mind, self, and society: From the standpoint of a social behaviorist*. The University of Chicago Press, Chicago.

Murali, V. and Oyebode, F. (2004). Poverty, social inequality and mental health. *Advances in Psychiatric Treatment*, 10 (3): 216-224.

Nalah, A.B. and Ishaya, L. D.(2013). A Conceptual Overview of Deviance and Its Implication to Mental Health: a Biopsychosocial Perspective. *International Journal of Humanities and Social Science Invention*, 2(12): 1-9.

National Research Council (US) Committee on Recognition and Alleviation of Distress in Laboratory Animals. (2008). *Recognition and Alleviation of Distress in Laboratory Animals*, National Academies Press (US), Washington, DC. Retrieved on 11 July 2016 from http://www.who.int/classifications/icd/en/bluebook.pdf

Nichter, M. (2010). Idioms of distress revisited. *Cultural Medical Psychiatry*, 34: 401-416.

Perry, Mellisa J. (1996). The relationship between social class and mental disorder. *Journal of Primary Prevention*,17 (1): 17–30.

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.

Ribeiro, W.S. (2009). Exposure to violence and mental health problems in low and middle- income countries: a literature review. *Rev Bras Psiquiatr,* 31(2): 49-57. Retrieved on 15 Apr.2016 from https://www.ncbi.nlm.nih.gov/pubmed/19967200

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

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

Schneiderman, N.et al. (2005). Stress and Health: Psychological, Behavioral, and Biological Determinants. *Annual review of clinical psychology*, 1:607-628.

Schwartz, S. and Corcoran, 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.

Schwartz, S. and Meyer, I.H. (2010). Mental health disparities research: The impact of within and between group analyses on tests of social stress hypotheses. *Social science & medicine,* 70(8):1111-1118**.**

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

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

Srivastava, K. (2012). Women and mental health: Psychosocial perspective. *Industrial Psychiatry Journal*, 21(1): 1–3.

Stryker, S. (2008). From Mead to a Structural Symbolic Interactionism and Beyond. *Annual Review of Sociology*, 34(15): 15-3.

Thoits, P.A. (2010). Sociological Approaches to Mental Illness. In Scheid, L. T. and Brown, N. T., editors, *A Handbook for the Study of Mental Health,* pages 1-5, New York, Cambridge University Press.

Warshaw, C. et al. (2009). Mental Health Consequences of Intimate Partner Violence. In Mitchell, C. and Anglin, D., editors, *Intimate partner violence: A health-based perspective*, pages 147-171, Oxford University Press, Oxford.

Wasco, S.M. (2003). Conceptualizing the harm done by rape: Applications of trauma theory to experiences of sexual assault. *Trauma, Violence, & Abuse*, 4: 309-322.

Wilson, P. J. (1967). Status Ambiguity and Spirit Possession. *Man, New Series*, 1(3): 366-378.

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