Chapter 3

Socio-Economic Profile of Mentally Ill and Their Families
CHAPTER III

SOCIO–ECONOMIC PROFILE OF MENTALLY ILL AND THEIR FAMILIES

The analysis of data is the most skilled task in the research process. Analysis means a clinical examination of the assembled and grouped data for studying the characteristics of the object under study and for determining the patterns of relationships among the variables relating to it. The purpose of analysis is to reduce data to intelligible and interpretable form so that the relations of research problems can be studied and tested. The data gathered are ordered in a systematic way so that the findings brought out and the conclusions arrived at have logical connection and meaning. Both qualitative and non-qualitative methods are used. It involves the application of various Statistical techniques. Statistical analysis of data summarizes large mass of data into understandable and meaningful form. This is the role of descriptive statistics. The reduction of the data facilitate further analysis. Statistics make exact descriptions possible and facilitates identification of the casual factors underlying complex phenomena. Statistical analysis facilitates for drawing of reliable inferences from observational data. This analysis aids in making generalizations from the results of sample surveys and also facilitates for hypotheses testing.

The data collected in organised manner from the family members of mentally ill and the end result of data is transferred into quantitative form. Such data are then summarised and subjected to statistical analysis. The data was analysed statistically by using the SPSS (Statistical package for social sciences) and tabulated. The discussions and interpretations are presented in this chapter in order to get conclusions in logical and understanding manner.

Not only that these factors do influence the behaviour of human beings. The socio-economic profile of the mentally ill is presented here in this chapter which would enable a better understanding of the problems of the mentally ill and their families. The profile of the mentally ill comprises their
age, gender, religion, caste, marital status, literacy level, mother tongue, occupation, income, residence, type of family, family orientation, family procreation and physical amenities available in their houses.

### Table 3.1

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Age</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>15-25</td>
<td>94</td>
<td>23.50</td>
</tr>
<tr>
<td>2.</td>
<td>26-35</td>
<td>76</td>
<td>19.00</td>
</tr>
<tr>
<td>3.</td>
<td>36-45</td>
<td>88</td>
<td>22.00</td>
</tr>
<tr>
<td>4.</td>
<td>46-55</td>
<td>83</td>
<td>20.75</td>
</tr>
<tr>
<td>5.</td>
<td>56-65</td>
<td>59</td>
<td>14.75</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.00</td>
<td></td>
</tr>
</tbody>
</table>

The data collected from mentally ill respondents at Psychiatric Department, Government General Hospital, Anantapuramu indicates that higher incidence of mental illness was observed in younger age group. The age wise distribution respondents as presented in Table No 3.1 indicates that sizable portion of them (23.50% ) were between the age group 15-25, which means they are affected by mental illness in a very young age, which is the most productive part of their lives. The inference drawn from this table stated that, younger generation are prone to social, psychological problems, and they are more sensitive and mentally fragile. The younger generation are more vulnerable to mental illness due to socio-economical stressors such as competition, poverty, deprivation, malnutrition, child labour, societal violence, alcoholism, smoking, death of persons, unemployment, overcrowding, parents attitude all these factors will carry major psychological problems in this age group.

Younger generation were vulnerable to mental illness also because it is a period of transition from childhood to maturity. This is the period when there is consolidation of personality and a beginning sense of identity as
mature person. This phase is, a specific tasks for adolescent may be identified as gaining independence from the family, sexual maturity, establishing meaningful relationships with peers of both sexes, and making decisions about life work and goals. Later adolescence (15-19 years), are related to career, marriage and parenthood. Characteristics trouble of the adolescent crisis may include psychosis, neurosis, delinquency etc. Early adulthood (18-35 years) and (35-50 years) are also more stressful because of family responsibilities.

Longitudinal research in recent years has shown that about one-half of mental morbidity in childhood continues in adulthood and contribute to personality disorders such as anti-social, affective disorders, somatisation disorders alcoholism and drug abuse, poor job performance, unstable interpersonal relationships, accident proneness and low academic achievement (Savita Malhotra, 2002).

A similar study in northern India also indicated a much higher prevalence in the geriatric group (43.3%) than in the non-geriatric group (4.6%). The risk of mental disorders with rising age has been replicated in a number of other studies. (Tiwari, S.C., 2000)

Several groups of elders may be especially vulnerable to suffer mental disorders. Older women report more psychological distress and may need specific intervention strategies to empower them (Jaiprakash, I., 1997). The results of the present study also show that majority of younger and middle aged patients are coming to Psychiatric Department of Anantapuramu for treatment. Old age people are also suffering with physical and psychological problems, undiagnosed physical illness were found to be more among mentally ill geriatric patients and elderly depressed patients.
The gender wise distribution of mentally ill respondents as presented in the Table No 3.2 indicates that out of 400 sample, Males are 53.50 per cent and females are 46.50 per cent. The inference drawn from this table is that more males are reported to psychiatric department than females. Overall rates of psychiatric disorders are more in women than men if compared as per 2011 Census of Anantapuramu District. The main reason was socio cultural factors, ‘No society treats its women as well as its men’. Most of women neglected in getting early treatment. Gender bias exits, in the treatment of psychological disorders.

Studies indicate that up to 20 % of women, those attending primary health care in developing countries suffer from anxiety and depressive disorders. In most centres, these patients are not recognised and therefore not treated. Communication between health workers and women patients are extremely authoritarian in many countries, making a women’s disclosure of psychological and emotional distress difficult and often stigmatised. Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely seek specialist mental health care and are the principal users of inpatient care.

Alcoholic problems and drug abuse problems are more in men than female. Women are more likely to have been treated for mental health problems than men (29 % compared to 17%). This could be because, when asked, women are more likely to report symptoms of common mental health
problems (Better or Worse: A Longitudinal study of the mental health of adults in Great Britain, National Statistics, 2003).

A community psychiatric survey stated that women had higher rates of psychiatric symptoms (Carstairs and Kapur, 1976). Indian women suffer from common mental disorders much more than men do. Both community based studies of treatment seekers indicate that women are, on average, two to three times, at greater risk to be affected by common mental disorders (Patel, V. et al., 1999 and Mumford, D.B. et al., 1997). As per the gender ratio women suffer more with mental illness than men.

Depression among rural women have been reported to be more than twice those of general population estimates for women (Hauenstein and Boyd, 1994). The study findings also conforms the same. The inference drawn from this Table stated that overall rates of psychiatric disorders are more in women than men as per the female and male census ratio of Anantapuramu District.

**TABLE: 3.3**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Religion</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Hindu</td>
<td>369</td>
<td>92.25</td>
</tr>
<tr>
<td>2.</td>
<td>Muslim</td>
<td>27</td>
<td>6.75</td>
</tr>
<tr>
<td>3.</td>
<td>Christian</td>
<td>4</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The religion wise distribution of mentally ill respondents as presented in the Table No 3.3 Shows that majority of respondents (92.25 %) were professed Hinduism. while Christians are meagre (1%) and Muslims (6.75 %). Religion and social life are closely intertwined. The other religions are not found in rural areas even if found they can be counted on fingers. The religion and life are closely intertwined and as old as mankind. Though religion is highly personal thing, yet it has a social aspect and social role to play. It has
been a powerful agency in society and performed many important social functions. Man does not live by knowledge alone. He is an emotional creature as well. Religion serves to soothe the emotions of man in times of suffering and disappointments and contributes to the integration of his personality (Arnold W. Green, 1952).

Studies show that mental disorders are common, affecting more than 25 percent of all people at some time during their lives. Religion plays a major role in controlling emotions and frustrations. Customs are more rigid in Hindus and Muslims, religion is sometimes too much associated with supernaturalism and dogmatism but the recent trends in religion have tended to place more emphasis on social values and less on dogma.

The inference drawn from the Table indicates that mental illness equally affected in all religions, Hindus are more reported to hospitals because of larger section of rural population professed Hinduism. As per the 2001 census, population of Anantapuramu was 36,40,478, among which Hindus 32,25,156 (88.6 %), Muslims 38,92,01 (10.7%), Christians 20,770 (0.57%). Hence major study participants are from Hindu religion.

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Caste</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Forward Class</td>
<td>124</td>
<td>31.00</td>
</tr>
<tr>
<td>2.</td>
<td>Backward Class</td>
<td>204</td>
<td>51.00</td>
</tr>
<tr>
<td>3.</td>
<td>Scheduled Class</td>
<td>59</td>
<td>14.75</td>
</tr>
<tr>
<td>4.</td>
<td>Scheduled Tribe</td>
<td>13</td>
<td>3.25</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The caste wise distribution of mentally ill shown in the Table No 3.4 is represented that majority of respondents (51%) were from Backward classes (BC), mostly from Kuruba, Padmasali and Golla. The inference drawn from this table stated that in Anantapuramu District, predominant section of the
The caste system is undemocratic because it denies equal rights to all irrespective of their caste, creed, or colour. Social barriers are erected specially in the way of lower class individuals who were not given freedom for the mental and physical development. Forward caste people also suffer with mental illness, only fewer reported to Government hospital for treatment and others probably approached Private hospitals. Most of the people may delay the treatment or may go to private hospitals because of stigma and having faith on services available at private sectors.

The failure of asylum is evident by repeated cases of ill-treatment to patients, lack of staffing, bad management and inadequate inspection and quality assurance procedures. (Goel, D.S. et al., Mental Health 2003). The findings of the present study specify that majority, of BC caste people reported to hospital for treatment. Among them, educational, occupational and economic status was low. Hence these factors may predispose to mental illness among BC Caste.

TABLE: 3.5
MARITAL STATUS - WISE DISTRIBUTION OF MENTALLY ILL RESPONDENTS

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Marital Status</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Unmarried</td>
<td>120</td>
<td>30.00</td>
</tr>
<tr>
<td>2.</td>
<td>Currently Married</td>
<td>259</td>
<td>64.75</td>
</tr>
<tr>
<td>3.</td>
<td>Divorced</td>
<td>6</td>
<td>1.50</td>
</tr>
<tr>
<td>4.</td>
<td>Separated</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>5.</td>
<td>Widowed</td>
<td>10</td>
<td>2.50</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
<td>100.00</td>
</tr>
</tbody>
</table>

Marital status wise distribution of mentally ill as presented in Table No 3.5 shows that majority of respondents(64.75%) were currently married. Marriage is the greatest event in an individual’s life and brings with it many responsibilities. Indian society is predominantly patriarchal. Marriage defined by the “The Oxford Dictionary” is a formal union of man and woman by which
they become husband and wife i.e. it is a consensual and contractual relationship recognised by law, it is almost compulsory for every individual to marry and “settle down”. Not being married is considered as stigma. Particularly in case women where as being married translates in to elevation of social status. They are stringent gender roles, with women having a passive role and husband an active dominating role. Marriage and motherhood are the primary status roles for women. Mental disorders can either results in marital discord or may cause by marital disharmony in predisposed individuals, marriage can cause mental illness. Divorce seeking couples have higher psychiatric morbidity than well-adjusted couples with more neurotic traits.

Studies consistently show greater distress among widowed, separated, divorced men and women. Greater distress is seen among married women compared to married men and greater distress in single women as compared single men against women with mental illness, many of them are ill-treated by their husbands and in-laws and are sent back to their parent’s house. This cause misery and stigma and further complicated their problems by making them more susceptible to development of psychiatric disorders after marriage. More women with mental illness got married. In the setting of mental illness many of the social values take their ugly form in the form of domestic violence, dowry harassment, dowry death, separation, divorce. Societal norms are powerful and often override the legislative provision in real life situations (Indira Sharma, et al., 2013, Ashish Srivasthava, 2013). The findings of the present study shows that (2.50 %) were widowed, (1.50 %) were divorced, (1.25 %) were separated, The inference drawn from this table indicates that major section of respondents were currently married. The findings of the present study also support the same.
TABLE: 3.6

SPOUSE-WISE DISTRIBUTION OF RESPONDENTS

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Spouse</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Related</td>
<td>49</td>
<td>17.50</td>
</tr>
<tr>
<td>2.</td>
<td>Not related</td>
<td>231</td>
<td>82.50</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>280</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The data presented in the above Table No 3.6 indicates that major section of spouses (82.50 %), were not related with maternal and paternal. The data presented in the Table No 3.7 shows that majority of marriages (73.47 %) were taken place among maternal side. Mental illness also observed in consanguineous marriages. The inference drawn from this Table stated that mental illness observed among both related marriages as well as not related marriages.

TABLE: 3.7

DISTRIBUTION OF SPOUSES BY RELATIONSHIP

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>If related</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Maternal</td>
<td>36</td>
<td>73.47</td>
</tr>
<tr>
<td>2</td>
<td>Paternal</td>
<td>13</td>
<td>26.53</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

Studies have shown that about 75% of mental defectives and 33 % of psychotic individuals owe their condition mainly due to unfavourable hereditary. Family traits seem to run through generations. Some mental illness like OCD (Obsessive Compulsive Disorder) might represent a more familial form of the illness in India. Several clinical investigations carried out from Bangalore, some of which reported on familial risk of OCD (Guruswamy, R. et al., 2002).

Schizophrenia and Bipolar Disorders can have a devastating impact, due to frequent onset during adolescence or early adult life. Some Indian group have led the efforts to map genes for schizophrenia and mood
disorders, using DNA technology. Genetic Epidemiological studies in schizophrenia and mood disorders stated that members of families, with an affected relatives are at an increased risk for the disorder.

A study conducted regarding psychiatric morbidity among 798 first degree relatives of 126 cases with Schizophrenia and related disorders and found that the risk for Schizophrenia was elevated among relatives of Probands, the spectrum ranging from affective disorder to psychiatric disorders (Linda, F.K.et al. 2002). The findings of the present study also support the same. The inference drawn from this Table indicates that marriages from relatives can increase the risk of mental illness because of genetic influence.

**TABLE: 3.8**
MOTHER TONGUE – WISE DISTRIBUTION OF MENTALLY ILL RESPONDENTS

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Language</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Telugu</td>
<td>367</td>
<td>91.75</td>
</tr>
<tr>
<td>2.</td>
<td>Urdu</td>
<td>27</td>
<td>6.75</td>
</tr>
<tr>
<td>3.</td>
<td>Others</td>
<td>6</td>
<td>1.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

**TABLE 3.9**
DISTRIBUTION OF RESPONDENTS BY LEVEL OF EDUCATION

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Education</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>No Schooling</td>
<td>161</td>
<td>40.25</td>
</tr>
<tr>
<td>2.</td>
<td>Primary Education</td>
<td>48</td>
<td>12.00</td>
</tr>
<tr>
<td>3.</td>
<td>Upper primary education</td>
<td>43</td>
<td>10.75</td>
</tr>
<tr>
<td>4.</td>
<td>Secondary Education</td>
<td>69</td>
<td>17.25</td>
</tr>
<tr>
<td>5.</td>
<td>Intermediate</td>
<td>32</td>
<td>8.00</td>
</tr>
<tr>
<td>6.</td>
<td>Degree</td>
<td>31</td>
<td>7.75</td>
</tr>
<tr>
<td>7.</td>
<td>PG</td>
<td>8</td>
<td>2.00</td>
</tr>
<tr>
<td>8.</td>
<td>Professional</td>
<td>8</td>
<td>2.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>
The data presented in Table No 3.9 reveals that majority of the respondents (40.25%) are illiterates. The inference drawn from this table shows that illiteracy rates are high among mentally ill. In India because of poverty, ignorance, culture and traditions like female illiteracy, lack of access, child labour, commercial educational system, lack of awareness among parents regarding education, illiterate parents etc. Low literacy is a major factor influencing health status. The world map of illiteracy closely coincides with the maps of poverty, malnutrition, ill health, high mortality rates.

Education as a driving force for better health, make better use of health care services in order to prevent mental illness. The 1948, the Declaration of Human Rights stated that everyone has a right to education. Yet, even today, the right is being denied to millions of children. Education is a crucial element in economic and social development. Without education, development can neither be broad based nor sustained. The benefit that accrue to a country by having a literate population are multidimensional. Spread of literacy is generally associated with modernization, urbanization, industrialization, communication, and commerce. It forms an important input in the overall development of individuals enabling them to comprehend their social, political and cultural environment better and respond to it appropriately. Higher levels of education and literacy lead to greater awareness and also contribute to improvement of economic conditions and is a prerequisite for acquiring various skills and better use of health care facilities.

The study conducted among the Rural Elderly in Chittoor District, Andhra Pradesh. The depression was high among the elderly who were aged 80 years and above, females, illiterates, those who were below the poverty line, economically partially dependent, and those depended totally for the activities of daily living. These factors were significantly associated with depression (Swarnalath, N., 2013). The findings of the present study also concluded that mental illness was associated with low literacy rates.
### TABLE: 3.10

**OCCUPATION WISE DISTRIBUTION OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Occupation</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>House wife</td>
<td>50</td>
<td>12.50</td>
</tr>
<tr>
<td>2.</td>
<td>Coolie</td>
<td>202</td>
<td>50.50</td>
</tr>
<tr>
<td>3.</td>
<td>Cultivation</td>
<td>72</td>
<td>18.00</td>
</tr>
<tr>
<td>4.</td>
<td>Technical</td>
<td>10</td>
<td>2.50</td>
</tr>
<tr>
<td>5.</td>
<td>Services</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>6.</td>
<td>Business</td>
<td>14</td>
<td>3.50</td>
</tr>
<tr>
<td>7.</td>
<td>Currently Unemployed</td>
<td>10</td>
<td>2.50</td>
</tr>
<tr>
<td>8.</td>
<td>Students</td>
<td>37</td>
<td>9.25</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The occupation wise distribution respondents as presented in the Table No 3.10 shows that major section of respondents (50.50%) are coolies. The minor section of patients (1.25%) are under category of service such as clerical staff, warden etc. The inference drawn from the above table specify that majority of people are working as coolies. The reasons are illiteracy, unemployment, poverty, urbanization etc. Unemployment usually lead to low income which in turn leads to malnutrition, psychological damage and social damage, higher incidence of ill health and death. For many individuals, the occupation is the main sources of income. Work often plays a role in promoting both physical and mental health. The factors associated with occurrence of common mental disorders were unemployment, poverty and others, which in turn are linked to a wide variety of social, economic and cultural issues as per the review (Patel, V., 1999 a).

During the second half of the 1980s, the number of people living in extreme poverty in the world has increased, and was estimated at over 1.1 billion in 1990 – more than one – fifth of humanity. Poverty yields its destructive influence at every stage of human life from the movement of conception to the grave. Poverty is the main reason for not getting the
treatment, it is the main reason for low life expectancy, low birth weight babies, higher maternal mortality, handicap and disability, mental illness, stress, suicide, family disintegration and substance abuse (WHO, 1995). The findings of the present study also support the same.

### TABLE: 3.11

**MONTHLY INCOME WISE DISTRIBUTION OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Monthly Income</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>No income</td>
<td>97</td>
<td>24.25</td>
</tr>
<tr>
<td>2.</td>
<td>&lt;5000</td>
<td>235</td>
<td>58.75</td>
</tr>
<tr>
<td>3.</td>
<td>5001-10000</td>
<td>60</td>
<td>15.00</td>
</tr>
<tr>
<td>4.</td>
<td>10001-15000</td>
<td>5</td>
<td>1.25</td>
</tr>
<tr>
<td>5.</td>
<td>15001-20000</td>
<td>2</td>
<td>0.50</td>
</tr>
<tr>
<td>6.</td>
<td>&gt;20000</td>
<td>1</td>
<td>0.25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The data presented in above Table No 3.11 shows that majority of respondents (58.75%) are related to low income group below 5000 rupees per month. The per capita G N P (Gross national product) is the most widely accepted measure of general economic performance. Economic progress that has been the major factor in reducing morbidity, increasing life expectancy, and improving the quality of life. The economic status determines the purchasing power, standards of living, quality of life, family size, the pattern of diseases and deviant behaviour in the community.

India’s population has been steadily increasing since 1921. The year 1921 is called as “big divide” because the absolute number of people added to the population during each decade. India’s population is currently increasing at the rate of 16 million each year. One of the important reason was the over population. Other major reasons for low income in India are more competition for job, lack of resources, capitalism, industrialization, lack of land.
for cultivation etc. Income, occupation, education are the major components correlated with health status.

Mental illness, also have been reported among low income people. Less income leads to poor nutrition, stress, debts which indirectly influence on health status. Unemployment has multiple effects on an individual, which extend beyond financial burden. Employment provides an independent income and a sense of identity. It fills an empty day with purpose. Unpaid voluntary work may serve this purpose.

A trial study was conducted with 240 low-income women suffering from major depression to examine the effectiveness of multi-component intervention that included psycho-educational group intervention, structured and systematic follow up, and drug treatment for those with severe depression. The results showed that 70% of the stepped-care group had recovered as compared with 30% of the usual-care group (Araya, R. et al., 2006). The findings of the study also support these findings. The inference drawn from this Table is stated that low income results in poor quality of life like lack of shelter, poor nutrition, lack of sanitation etc. Low income is the leading cause for stress. Low income groups are high risk for mental illness because of lack of job satisfaction, heavy work, less wages and more working hours etc. may produce constant pressure, anxiety and stress. Stress is the leading cause for mental illness.

**TABLE: 3.12**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Place of birth</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Rural</td>
<td>321</td>
<td>80.25</td>
</tr>
<tr>
<td>2.</td>
<td>Sub Urban</td>
<td>18</td>
<td>4.50</td>
</tr>
<tr>
<td>3.</td>
<td>Urban</td>
<td>61</td>
<td>15.25</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>
The place of birth wise distribution respondents as presented in Table No 3.12 reveals that majority of patients (80.25%) are residing at rural area. It is now recognised that cultural factors are deeply involved in all the affairs of man, including health and illness. Rural population mainly influenced by cultural factors. The life patterns of people were fixed. Their habits, attitudes and ideas are sharply marked off from those of the people living in the urban area. The inference drawn from the above Table shows that rural people are having more misconceptions towards mental illness than urban population because of lack of awareness, ignorance and supernatural causes.

Many times Mental illness can be cured by prayers as well as marriage. Stigma remains a powerful negative attribute in all social relations. There is a deficiency in care at the community level in India. It is reported that the ability to recognise the mental disorder is a central part of mental health literacy because it is a prerequisite for appropriate help seeking. Literacy rate is low in rural communities. Elderly living in rural areas may represent another risk group, because rural areas lack resources, and with agriculture being the main occupation, there is neither income security nor any systematic provision. Older people in urban slums grapple with the twin problems of poverty integration rather than social isolation per se and the lack of occupation are related to morbidity (Venkoba Rao, A and Madhavan, T., 1982). The findings of the present study also support these findings.

In rural areas stigma and misconceptions are more predominante to seek medical care. The health facilities also not easily accessible, majority of rural people having faith on folk healers and they were depend on harmful practices which results in worsening of disease condition. The findings of the present study also concluded the same.
The data presented in Table No 3.13 conforms that the majority of respondents (66%) are currently residing in rural areas. Studies conducted on prevalence of mental disorders by analysis of ten Indian studies. Results stated that urban morbidity rate was 2 per 1000 higher than the rural rate. It has been stated that rural epidemiological studies are more difficult to conduct as compared to urban ones due to ignorance, stigma, and lack of resources. Many disorders like substance abuse, obsessive compulsive disorders often go unaccounted. Visible mental disorders like epilepsy and hysteria are accounted in a more reliable manner and are significantly more common in rural communities.(Murali Madhav, S., 2001).

Rural life is also fought with problems for many people. Isolation, lack of transport and communication and limited educational economic opportunities are common difficulties. Moreover, mental health services tend to concentrate clinical resources and expertise in larger metropolitan areas, leaving limited options for rural inhabitant in need of mental health care (WHO, 2001). The results of the present study, also supporting the same. The inference drawn from this Table concluded that more rural people reported to psychiatric department than urban people.

Urban people having feasibility to go to private psychiatric clinics. Hence most of the urban patients were less reported to Government hospital. Most of the times patients were not reported to hospitals, in the early stage,
because of stigma and ignorance. Most of the times patients seeking medical care were in severe stage such as aggressive, violent, suicidal behaviour, destructive nature, and severe depression etc.

**TABLE NO: 3.14**  
**TYPE OF FAMILY WISE DISTRIBUTION OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Type of family</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Nuclear</td>
<td>305</td>
<td>76.25</td>
</tr>
<tr>
<td>2.</td>
<td>Joint Family</td>
<td>95</td>
<td>23.75</td>
</tr>
<tr>
<td>3.</td>
<td>Total</td>
<td>400</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The type of family wise distribution respondents as presented in Table No 3.14 reveals that majority of them, (76.25%) are belongs to nuclear families. The inference drawn from this table show nuclear families more vulnerable to mental illness than joint families. The nuclear family is a smaller family. It is no longer a joint family, the joint families are stable type of family, social mobility was slight, but today it is all changed. In nuclear families the control of the family over its members has decreased. The younger generation does not like any interference by their elders. There is lack of unity among the family members. The problems of working women hindered the development of children and increased conflicts between the wife and husband, the marriage bonds have weakened. The ancient ideal of fidelity in sex-relationship has been adversely affected. Pre-marital and extra-marital relationships have increased. There is sexual disharmony between husband and wife. Increased divorce rates in nuclear families results in family instability.

Reviews of the role of the family in relation to mental health have found that the nuclear family structure is more likely be associated with psychiatric disorders than joint families, the traditional join family that exists
in India is seen as sources of social and economic support and is known for its tolerance of deviant behaviour and capacity to absorb additional roles in times of crisis. (Sethi, B.B., 1985).

Research indicate that higher rates of psychiatric illnesses are among those from nuclear families or living alone, highlight the need for family cohesion and support (Ramachandran, et al., 1981). The findings of the present study also confirms the same.

TABLE NO: 3.15

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>House</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Own</td>
<td>300</td>
<td>75.00</td>
</tr>
<tr>
<td>2.</td>
<td>Rent</td>
<td>89</td>
<td>22.25</td>
</tr>
<tr>
<td>3.</td>
<td>Leased</td>
<td>11</td>
<td>2.75</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The house wise distribution respondents as presented in Table No 3.15 reveals that majority of respondents (75%) are residing in own house. Own houses provide security and safety to the family. Housing important for shelter, family life, access to community facilities, family participation in community life, and economic stability.

TABLE NO: 3.16

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Type of house</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Thatched</td>
<td>141</td>
<td>35.25</td>
</tr>
<tr>
<td>2.</td>
<td>Tiled</td>
<td>70</td>
<td>17.50</td>
</tr>
<tr>
<td>3.</td>
<td>Terraced</td>
<td>189</td>
<td>47.25</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>400</td>
<td>100.00</td>
</tr>
</tbody>
</table>

The data presented in the Table No 3.16 shows that 47.25 percent have terraced houses and 17.50 percent are living in tiled houses.
TABLE No: 3.17
ELECTRICITY WISE DISTRIBUTION OF RESPONDENTS

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Electricity</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Yes</td>
<td>397</td>
<td>99.25</td>
</tr>
<tr>
<td>2.</td>
<td>No</td>
<td>3</td>
<td>0.75</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The researcher tries to find out the electricity facilities of respondents. The data presented in Table No. 3.17 conforms that majority of respondents (99.25%) are having electricity in their houses. The inference drawn from this table indicates that majority of respondents meeting their basic needs.

TABLE NO: 3.18
WATER SUPPLY WISE DISTRIBUTION OF RESPONDENTS

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Water supply</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Tap</td>
<td>370</td>
<td>92.50</td>
</tr>
<tr>
<td>2.</td>
<td>Well</td>
<td>4</td>
<td>1.00</td>
</tr>
<tr>
<td>3.</td>
<td>Bore</td>
<td>26</td>
<td>6.50</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
</tr>
</tbody>
</table>

The responses of the family members of mentally ill as presented in Table No 3.18 states that majority of families (92.50 %) are getting water supply from taps, only (1%) are getting water from wells. The safe water supply is important to prevent contagious diseases and to prevent systemic infections.

Mental health in childhood and later depends very much on our basic needs being satisfied. Mental hygiene specialists have emphasised that when these needs are adequately cared for, the individual functions in an effective manner. Our basic needs are physical, organic as well as emotional or psychological. The organic needs are to be satisfied for maintaining physical well-being. The inference drawn from the above Tables stated that all basic needs should be satisfied in order to maintain physical wellbeing. An
individual behaviour is also influenced by his needs. Behaviour is also described as an adjustment to meet the needs of given situation. For example, when person is not able to meet the needs results in losing temper and complaining to everyone, isolating oneself, making excuses for failure etc. (Bhatia, B.D., 2012). The findings of the present study are not supporting with these concepts because most of patients are meeting their basic needs according to the results of the study.

**TABLE NO: 3.19**

**DRAINAGE WISE DISTRIBUTION OF RESPONDENTS**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Drainage</th>
<th>No. Of Respondents</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Closed</td>
<td>14</td>
<td>3.50</td>
</tr>
<tr>
<td>2.</td>
<td>Opened</td>
<td>386</td>
<td>96.50</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>400</strong></td>
<td><strong>100.00</strong></td>
<td></td>
</tr>
</tbody>
</table>

The drainage wise distribution of respondents as presented in Table No3.19 reveals that majority of respondents (96.50%) are having open drainage system. In India drainage facilities were poorly established. The inference drawn from above Table indicates that poor drainage system leads to water pollution and soil pollution which in turn results in acute infections. Drainage system is also important to maintain healthy environment. Poor drainage system results in communicable diseases. Severe physical illness is the major predisposing factor for mental illness.

It is observed that birth order wise, data collected from the family members of mentally ill specify that majority of mentally ill respondents (46.25%) are the first child in the birth order and (31%) are second child, (13.75 % ) are third child, (8.75% ) are forth child in family, very minor section of children (0.25 % ) are above the fourth child in family . The inference drawn from this data concluded that first child in the family were more affected with mental illness. The main reason was faulty parent child relation
like over protection and over leniency. Over protection may hinder the normal growth and development and not able to cope up with reality. A child with no sibling, who is given extra protection and care, is likely to develop into an individualistic or self-centred child, demanding and selfish. Cruze(1951) says, ‘an individual personality is influenced by the reactions of other people to him and by his reactions to other people than by any other factor in the environment’. Of these social factors, the most important are the relationships in the home, and the family, the influence of the school and the playground, the social codes and social roles which the individual has to play in the family environment and in the community. If the home is characterised by an atmosphere of peace, love, mutual understanding, harmony and respect, the child is likely to develop a self-confident and secure personality. If the child is not given opportunity to exercise his independence or use his initiatives, and is over protected, he is likely to develop an over-dependent personality. Repressive discipline will result in rebelliousness or dependence as personality traits. Over protected and over leniency towards child results in inferiority, shame and doubt in their own abilities. These feeling continued in later life. They are not able to maintain intimacy with others can lead to isolation, loneliness and sometimes depression and hopelessness. Even easily frustrated and not able to resolve his psychological conflicts, they will attempt to resolve psychological conflicts by denying the harsh and painful reality world and living in a phantasy world full of pleasers.

To sum up, the description of the Socio-Economic Profile of the mentally ill reveals the fact that the respondents are having basic amenities of life such as housing with electricity, and water supply. Most of the respondents are Hindus in their young and middle age from low income rural nuclear families. Most of them are married and are predominantly of Backward class Background.