SOCIAL STRUCTURE AND MENTAL ILLNESS: A SOCIOLOGICAL STUDY OF GENERAL HOSPITAL, GURGAON

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SUMMARY

INTRODUCTION

Mental illness is one of the most serious problems in the world today. Simply stated, it causes a living hell for both the afflicted people and those around them. Mental illness as social problem in India has received little attention from the relevant quarters owing to a host of conscious and unconscious reason. Mental illness is more or less an unexplored field in India, particularly from the social-psychiatric point of view. It is normally considered a problem, which is technically enigmatic and socially stupendous. From the time of conception, individuals are exposed not only to a physical and chemical environment, variation in climate, nutrition, and somatic health, but also to a series of social, psychological and cultural phenomena that influence and enrich the process of learning which determine, to a large extent, the individual experience, character and response.

Mental health disorders are actually much more prevalent than its apparent on the surface. While such disorders do not contribute significantly to mortality, they have a serious bearing on the quality of life of the affected persons and their families. Sometime based on religious faith, mental disorders are treated as spiritual affliction. Serious condition of mental disorders required hospitalization and treatment under trained supervision. Mental health institutions are woefully deficient in physical infrastructure and trained manpower. The National Health Policy of 2002, in which the network of decentralised mental health services for ameliorating the more common categories of disorders are envisaged. The programme outline for such disease would involve the diagnosis of common disorders, and the prescription of common therapeutic drugs, by general medical staff. In regard to mental health
institutions for indoor treatment of the patients, the policy envisages the upgrading of the physical infrastructure of such institution at central government expenses so as to secure the human rights of mentally ill vulnerable segment of society.

The specific vulnerable population, children, disaster population, tribal population, the elderly population, and homeless mentally ill, is included for mental health care planning. National Mental Health Programme was implemented to provide services to rural as well as urban population. However, even today 80 per cent of the rural population do not get these services. Multidisciplinary approach for the treatment of mentally ill is confined to only few institutions. Importance is attached to treat the mentally ill patients and not much thought is given to prevent mental illness and promote mental health. More importance is given to biological psychiatry and psychopharmacology, and psychology and social psychiatry are not given due importance.

The very conception of mental disorder of abnormal behaviour involves an understanding of its normal counter part, mental health. Both aspects are equally significant the former is the problem and the latter is the goal. There is no typical model of man to help us in distinguishing mental health from mental disorder. However, a few operational definitions are needed to clarify. The widely accepted definition of health as stated in the constitution of the World Health Organization, formulated in 1947 is as follow: “Health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity.”

In 1948 the International Preparatory Commission of the International Congress on mental health, considering mental health more specifically, proposed a definition which states: “Mental health is a condition which permits the optimal development, physical intellectual and emotional, of the individual, so far as this is compatible with that of other individuals. A good society is one
that allows this development to its members while at the same time ensuring its own development and being tolerant towards other societies” (Cameron: 1955). This definition is important as it brings into consideration the relationship of the individual’s mental health. Soddy (1950:72) suggested among other points, that the healthy mind can meet with all normal environmental situations and that the healthy minded person has the capacity to live harmoniously in a changing environment.

Mental illness is primarily manifested in behaviour and the terms ‘mental disorder; ‘mental illness’ or mental disease’ refer to a large number of disorders. Some of them are quite distinct from others and some merging almost imperceptibly into others in the behaviours and feeling exhibited by the patients who have difficulty in getting along with others, and who lack the ability to live a useful life. Mental illness is a psychiatric disorder that results in a disruption in a person’s thinking, feeling, moods, and ability to relate to others. It is distinct from the legal concept of insanity.

India is a multicultural country. It is commonly believed in India that after every twenty-five miles or so we come across people with a different culture and a different dialect. Custom and traditions vary from region to region. Yet, of course, some commonality does exist in the social structure. Social Structure is a term used in the social sciences to refer to patterned social arrangements which form the society as a whole, and which determine, to some varying degree, the actions of the individuals socialized into that structure. The meaning of social structure differs between various fields of sociology. Social structure may be seen to influence important social systems including the economic system, legal system, political system, cultural system, and others. Family, religion, law, economy and class are all units of social structures.

Social structure can also be divided into microstructure and macrostructure. Microstructure is the pattern of relations between most basic
elements of social life, that cannot be further divided and have no social structure of their own (for example, pattern of relations between individuals in a group composed of individuals—where individuals have no social structure, or a structure of organizations as a pattern of relations between social positions or social roles, where those positions and roles have no structure by themselves). Macrostructure is thus a kind of 'second level' structure, a pattern of relations between objects that have their own structure (for example, a political social structure between political parties, as political parties have their own social structure). Some types of social structures that modern sociologist differentiate are relation structures (in family or larger family-like clan structures), communication structures (how information is passed in organizations) and socio-metric structures (structures of sympathy, antipathy and indifference in organisations. Now below we will discuss the relationship between social structure and mental illness.

The discourse on social structure and mental illness conclude that structural variables are important in understanding the mental illness and then it suitability focuses on the treatment process. However, before jumping to the etiology, treatment process of mental illness, we would like to focus on the varied theoretical perspective, which are the outcomes of different discourse on mental illness given by sociological thinkers. We turn to them below.

**SOCIOLOGICAL PERSPECTIVES ON MENTAL ILLNESS:**

A modern sociological theory associated with mental health is anomie theory formulated by Durkheim. In his book titled “Suicide”, Durkheim remarkably demonstrated that suicide rate varies in function of social integration and collective regulation (Durkheim: 1951). Using different levels of both concepts of social integration and collective regulation, he postulated the existence of four types of suicides.
One of the four typologies of suicide is the egoistic suicide. According to Durkheim, the most important characteristic of the egoistic suicide is that it is connected with a low degree of social integration. In clear terms, individuals who are not well socially integrated commit the egoistic suicide. However, these individuals who score low on social integration can avoid taking the path of suicide if the collective conscience is strong. In the absence of strong social cohesion and strong social constraint in the form of norms, values, and morals for example, these individuals are more likely to commit suicide. Another type of suicide is altruistic suicide. The traits of this second type “are the opposite of those characterizing egoistic suicide”. Compared to the egoistic suicide, which is linked to low social integration, the altruistic suicide is connected to high social integration. Thus the altruistic suicide is the opposite of the egoistic one. The third type of suicide in Durkheim’s system is the anomic one. “Contrasting both with the first variety…and with the second” variety of suicide, this type of suicide is related to a low degree of social constraint. According to Durkheim, in the absence of a strong “system of collective states of conscience” the impulse takes over the individuals’ behaviors. With less social censure, the individuals give satisfaction to their wildest imaginations, which for the most part lead toward suicide. Durkheim associates this third type of suicide to the lack of social stability and order. The fourth and the last type of suicide is designated as the fatalistic suicide. As it was in the case of the first two types, the fatalistic suicide is the exact opposite of the anomic suicide. These types of suicides reflect different degrees of social constraint. While the anomic suicide is associated with low level of social constraint, the fatalistic suicide is attributable to an “excessive regulation” (Durkheim: 1951: 276).

Another modern sociological theory related to mental illness is the structural strain theory postulated by the American sociologist Robert Merton (1957). Though primarily used to explain deviance, the strain theory is also
helpful in shedding light on individuals’ mental health problems. The explanation of the deviance phenomenon offered by Merton is mainly focused on such concepts as institutional norms, cultural goals, prescribed and proscribed behaviors, and anomie. According to Merton, the variation in rates of deviant behaviors depends on variation in cultural goals and institutional norms. Cultural goals are the purposes and the interests “held out as legitimate objectives…”. Institutional norms are acceptable social mores that regulate the modes of “reaching these [cultural] goals”. Prescribed behaviors result from the equilibrium between cultural goals and institutional norms. Proscribed behaviors, or non-conformity, to the social structure occur as a result of an imbalance between the two factors. For example, an emphasis on the cultural goals at the expense of the institutional norms will lead to deviance, as will the opposite. Applied in the case of the United States, for example, this theory allows Merton to argue that the “heavy emphasis on wealth as a basic symbol of success” without a strong emphasis on the way of reaching it constitutes the source of the proliferation of deviance in American society. It is then this disequilibrium between the financial goals and the means to reach them (such as education and employment) which results in anomie.

AIMS AND OBJECTIVES OF THE STUDY:

The central focus of the study is to understand the etiology of mental illness in relation with the social structure of Indian society. The four fold research objectives are as follows:

1. To know the Socio-economic background of mentally ill.

2. To unfold the etiological factors which are active in the pre-disposition of mental illness.

3. To know societal response towards mental illness and its sufferers.
4. To understand the views of medical practitioner and indigenous practitioner towards the mentally ill patients.

METHODOLOGY:

Keeping in view the objectives of the study the exploratory research design has been used to analyse the basic issues pertaining to mental health.

FIELD OF THE STUDY:

Gurgaon, a district of Haryana state is situated in NCR of Delhi. The district derived its name from the name of Guru Dronachaya; the village was given as gurudakshina to him by his students; the Pandavas and hence it came to be known as Guru-gram, which in time got distorted to Gurgaon. This district has been existence since the time of Mahabharata. The District is surrounded by Delhi and Rajasthan. People are coming to Delhi from all over India for employment. But because of limited options of employment in Delhi everybody is not able to accommodate themselves in Delhi. When someone of them not find suitable jobs for themselves, than they start to keep an eye on nearby cities. One Another reason is that Delhi being a Capital of India is very costly city.

Gurgaon is a fast growing metro city. People of all types who are not able to accommodate themselves in Delhi are coming to Gurgaon ranging from maid servants, petty worker workers, construction workers, executives, Information Technology professionals and other types of workers. Thus influx of population has resulted in many types of physical and mental problems. Consequently it results into depression and other types of mental illness. To understand the mental illness from socio-cultural perspective, we have conducted a study of mentally ill patients in the Out Patient Department (OPD) of Psychiatric Department of General Hospital, Gurgaon.
SAMPLING:

On an average this hospital has approximately 1000-1200 patients who are visiting to different Out Patient Department (OPD) daily and out of them approximately 40-50 patients visit to the OPD of Psychiatric Dept. Therefore, looking to the magnitude of the problem, we have decided to conduct our fieldwork in the OPD of Psychiatric Department. We took sample of patients from the OPD during the three months period i.e. from February 2012 to April 2012.

Purposive sampling technique is used. We made the list of patients who visited during three months period (February 2012 to April 2012) and then whosoever was coming second time for their treatment was selected. In above said period 1057 new patients came to this OPD. Out of them, 399 visited OPD second time. But we could interview only 4 patients per day. It means that in three months period, we could interview 213 mentally ill patients. To know the socio-economic and etiological background of the patients, we interviewed their family members as mentally ill person are sometime not coherent in their response. Our emphasis is to understand the response towards mentally ill from the attendants/guardians so the suffering of mentally ill can be understood comprehensively. We have also taken some case histories and narrations reported by their attendants/guardians. Doctors and Indigenous faith healer are also interviewed to understand their line of treatment and their views towards mentally ill.

For understanding the view of professional doctors and faith healers for treatment of mental illness, we used the snowball technique. One doctor was interviewed from the OPD of the Psychiatric Department of General Hospital and four doctors were interviewed who were having their clinics in different locations in the city of Gurgaon. On the other hand, five faith healers were also interviewed which included fakir, siyane, Bengali doctor, etc. We approach
these doctors and faith healers as reported by the attendants/guardians of the mentally ill patients. In the process of interview they at some point of time consulted them for the treatment of mentally ill. Since, it was difficult to interview all the doctors and faith healers from whom the mentally ill have their treatment in the past. However, we tried to contact the doctors and faith healers to whom majority of the mentally ill patients confined their frequent visit to these doctors and faith healers.

FIELD EXPERIENCE AND TECHNIQUES OF DATA COLLECTION:

My interest in the subject started, when I first started my job in the General Hospital at Gurgoan. When I looked at the mental patients, physically they seem to be perfect but mentally they were disturbed and that promoted me to study the social structure, causative factors and treatment pattern of the patients. While reviewing thoroughly the available literature on mental illness in India, it became a starting point for deeper theoretical insight into its social structure. I became further aware of the scientific literature which largely neglected the in-depth study of social structure and etiology of mental illness. It was tough challenge to know and write about mentally ill patients and also covering the societal reactions towards them. It took more than six months (February 2012 to July 2012) to me for field work including the hospital and peoples and professionals views about mental illness.

Along with observation, interviews and case study method, we also conducted field work as primary tool of data collection. A detailed interviews schedule which was presented before hand with both open ended and close-ended questions proved helpful in the field. The field research intends to elicit participant situated knowledge based on interpretations of their own experiences, necessary to understand and analyses the culture. Although the prolonged field study in hospital situation helped in understanding the various processes with some indirect responses given by the attendants/guardians, I got
certain interested information which I could bring together to a basic understanding of the situation. Structured interviews always created a formal kind of atmosphere and the people sometimes get bored and tired of answering, so informal interviews were conducted to get the better insight. As it was difficult to interview different mentally ill, so the attendants/guardians were questioned as he/she is well informed and usually the caretaker of mentally ill and can give better information. Apart from data collection through interview schedule, some exclusive unstructured interviews with the help of guideline questions were also conducted. These interviews gave me useful information on the changing structure. Wherever it was difficult to carry out interview in Hindi, local dialect was used to collect information regarding the treatment process, we interviewed the psychiatrists and faith healers with the help of unstructured schedule.

Along with the primary data, secondary sources were of great importance as without understanding the past, it would have become difficult to understand the process of social change and continuity. Secondary sources included survey reports, Census reports, gazetteer, statistical information, research papers, articles and literature on mental illness in printed form and on web.

Fieldwork inculcated in me a sense of maintaining continuous relationship with the people and mentally ill patients. It is a never-ending process.

**FINDINGS AND CONCLUSION**

The data revealed that out of total 213 respondents, majority of them belonged to male respondents. Regarding age, majority of the respondents belonged to age group between 15-35 years. Most of the respondents were married. It was further analysed that majority of the respondents were educated upto middle class level followed by high school. On examining the occupation
of the respondents, majority of the respondents were unemployed and belonged to lower income group. Most of the respondents belonged to Hindu religion and belonged to general castes among Hindus. Regarding locality of the respondents, majority of our respondents belonged to urban areas. When we threw a light on size of the family, it was found that the majority of the respondents had 4-5 members in their family. On analyzing children of the respondents, it was found that the majority of the respondents had 1-2 numbers of children in their family. On examining the housing status of the respondents, it was found that majority of the respondents were residing in rented houses. It was further analysed from the data that majority of the respondents were non-migrated or local resident. On examining the age and sex of the respondents, it is evident from the data that majority of our respondents were male and belonged to the age group between 15-35 years. On analyzing sex and marital status of the respondents, it was found that that majority among male and female respondents were married. On examining literacy level with sex of the respondents, it was found that majority of our total respondents were literate, but male respondents were more literate as compared to female respondents and when we compared sex and education of the respondents, it was found that majority of our total respondents were low educated and belonged to middle school and high school respectively, but male respondents were more qualified as compared to female respondents. On analyzing monthly family income and the size of the family, it was found that the majority of the respondents in all income groups had 4-5 members in their family, while in the medium income group, majority of the respondents had 6-7 or more members in the family.

When we analyze the sex and types of mental illness of the respondents, it was found that majority of male and female respondents were facing F20-F29 and F30-F39 types of mental illness respectively. On analysing the type of illnesses and its duration, it was found that majority of the respondents were suffered from f30- f39 type of mental illnesses and had a
history of illness from 1 to 5 years followed by the respondents from same illness from 6 months to 1 year respectively. On analyzing the marital status and types of mental illness of the respondents, it was found that majority of our respondents in all types of marital status, were suffering from F30-F39 and F20-F29 type of mental illness respectively. When we analysed occupation and types of mental illness of the respondents, it was noticed that the majority of our male respondents were unemployed and were suffering from F20-F29 and majority of female respondents were housewives and were suffering from F30-F49 type of mental illness. When we examined the interest of respondents in studies during school days, it was found that majority of our total respondents were not interested in studies in school days. When we analysed the intellectual status of the respondents, it was found that majority of our respondents were extremely poor and sub-normal in intellect. When we threw a light on respondents’ life during school days, it was observed that the majority of our respondents were dull in school skills. On examining the Inter relationship within the families of respondents during their childhood, it was observed that the majority of the respondents had strained relationship with their family members in their childhood. Regarding family history of mental illness, it was found that that the majority of the respondents had no family history of mental illness. On examining the living status of parents of the respondents during childhood, it was observed that the majority of the respondents had their parents alive. But a considerable number of them had only father alive, some had their mother alive and some brought up by their step mother or step father. When we analysed the respondents’ position among siblings, it was found that the majority were the eldest child among their siblings. Regarding adjustment within house, it was found that the majority of the respondents were unadjusted in their family. When this adjustment analysed with outside the home, it was observed that the majority of the respondents were unfriendly hostility outside their home. When we analyze the
marital relations of the respondents, it was found that that among married respondents, the majority of the respondents had strained relationship. However, among widowers/ separated/ divorced respondents, the majority had disharmonious relationship between them. On examining respondents’ attitudes towards their children, it was found that the majority of the respondents had indifferent attitude towards their children. When attitude of the married respondents towards their marriage was analyzed, it was found that the majority of the respondents said that marriage has been a constant source of worries. On analyzing the attitudes of the unmarried respondents towards their marriage, it was observed from our data that the majority of the respondents were much anxious to marry. Regarding views of widowed, separated and divorced Respondents towards their marriage, it was noticed that the majority of the respondents were of the view that marriage was a support for life. When we analyze the attitudes of respondents towards religion, it was found that the majority of the respondents had indifferent attitude towards religions. When the attitudes of respondents’ father was analysed, it was found that the majority of the respondents’ father had moderate attitude towards religions. When the attitudes of respondents’ mother was analysed, it was observed that the majority of the respondents’ mother had moderate attitude towards religions. When we threw a light on the interest and means of recreation of respondents, it was found that the majority of the respondents were interested in watching pornographic movies. Regarding interest and activities of respondents during their adolescence, it was noticed that the majority of the respondents’ had no interests and activities followed by the respondents, who were indulged in masturbation. On examining addiction among the respondents, it was found that the majority of the respondents were addict of tobacco consumption followed by the respondents, who were addiction of alcohol consumption. When economic status of the male and female respondents after the onset of mental illness was analysed, it was found that the majority of the male and
female respondents’ were dependent on others. When we analysed the socially disapproved behaviour of respondent during their adolescents, it was found that the majority of the respondents were involved in drunkenness and substance abuse and in bad company. On analyzing nature of crime committed by respondents, it is obvious from the data that majority of the respondents were involved homicide crime followed by the respondents who committed robbery. Some of the respondents were taken by police into hospital as prisoner, out of them the majority of the respondents were under trial and some of the respondents were convicted prisoners. Regarding their stay in prison, majority of them were staying there for 3-7 years.

The data further reveals that regarding causes of mental illness according to attendants/ guardians, the majority were of the view that mental illness is a result of their deeds of previous life, domestic worries and wrath of god/goddess. On examining views of attendants/ guardians about neighbours’ attitudes toward mentally ill people, it was found that the majority of the mentally ill were taking mental illness as a matter of jokes and amusement to the people. They were also tortured and treated wickedly or considered victim of supernatural forces. On analyzing attendant’s/guardians views about the mental illness as stigmatization, it was found that majority of the respondents were of the view that mental illness is a stigma in the society. Regarding the parameters of stigmatization viewed by attendant/guardians, we found that majority of the respondents were of the view that mental illness creates problem in getting married, whereas a considerable number of them thought that it creates problems in job and it is very difficult to share the information of their kids/siblings about mental illness unlike other disease. When we examined revelation of truth about the mental illness, it was found that majority of the respondents would not tell at all to their relatives, while a considerable number of them tell their illness to doctors or indigenous practitioners.
The last section of the study deals with treatment patterns of mental illness. When we analyze about the treatment of respondents before coming to hospital, it was found that majority of the respondents have taken medical treatment before coming to hospital. On examining treatment received by respondent immediately after the first onset of their mental illness, it was observed that majority of the respondents have taken treatment from indigenous practitioner at the time of first onset of their illness. Regarding type of medical doctor from where treatment taken before coming to General Hospital, it was found that the majority of the respondents have taken treatment from M.B.B.S. or M.D. or other allied streams. After analyzing the multiple types of treatments of respondents, it was noticed that majority of the respondents have taken treatment of psychiatrists, but a sizeable number of them were taking indigenous type of treatment also. Thus, it is interesting to note that people still believe in indigenous treatment along with medical treatment. On examining the pattern of treatment by psychiatrist in the hospital, it was found that majority of the respondents were treated only by the medicines, but a sizeable number of them were treated by the combination of medicines and psychotherapy/counseling, but a negligible number of them were treated only counseling and psychotherapy. On analyzing the overall money spend on treatment during their mental illness, it was found that people not only believe in seeking treatment from the indigenous practitioner, as their indigenous practitioner came from the same socio-cultural background. Furthermore, it also concludes the cost of treatment from medical practitioner and indigenous practitioner differs significantly, which provokes the respondents to see indigenous practitioner as compared to medical treatment. On examining the source of reference to psychiatric treatment, it was observed that majority of the respondents referred to psychiatrist by the old patients of same OPD or their relatives respectively. Regarding the type of indigenous practitioners who treated the Respondents, it was found that the most of the
respondents have taken indigenous treatment from ‘Siyanas’. On examining the pattern of indigenous treatment received by respondents, it was observed that that majority of the respondents have gone to Mehndipur Balaji and Jharha phoonk for their treatment. Regarding motivational factors to consult with indigenous practitioners, it was found that the majority of the respondents have gone to the indigenous practitioner due to easy approachability, lack of awareness of psychiatric treatment respectively. On examining the views of practitioner about causes of mental illnesses, it was noticed that according to qualified doctors, heredity and organic factors and environmental and psychosocial factors are the main reasons of mental illness, while according to indigenous practitioners, the mental illness was a curse of religious factors and supernatural causes. When we asked about treatment part of mental illness all indigenous practitioners told that they could treat all type of mental illnesses.

Hence, it is concluded that people with mental illness are our nation’s largest minority group. It is the most inclusive group and, at the same time, the most diverse. Yet people who have been diagnosed with mental illness are all different from one another. The only thing they have in common is being on the receiving end of societal misunderstanding, prejudice and discrimination.

Considering the circumstances under which many Patients would access family relationship services, it would seem likely that mental health and wellbeing would play a prominent role in their reasons for seeking help. Responding to mental health issues will depend on the level of practitioners’ understanding, knowledge and skills, as will the extent to which they can intervene, assist, and/or incorporate such issues into service provision. Whilst providing mental health treatment to a person who has a mental illness may be outside of the scope of the practitioner’s role and/or knowledge and skill base, working with the family surrounding the person, or working with the person with a mental health problem regarding their relationships and family, may still be an option. The needs of carers and family members who are impacted upon
by a member’s mental illness should be attended to in their own right. This is in contrast to many current responses in the mental health service system that only consider these needs in relation to how they may benefit their unwell family member. There is also a public health opportunity within family relationship services to help ameliorate the stigma associated with mental illness and intervene early to prevent and reduce the risk and onset of mental health problems.