CHAPTER – I
INTRODUCTION

Mental illness, as we understand it today, is essentially the result of the influence of multiple dynamic forces. It includes a wide range of abnormal states of mood, thought and behaviour, ranging from mild anxiety and tension to severe disorganization psychosis. Attempts to cope with the problems of the mentally ill have existed since ancient times, but only in the last two centuries, systematic and rational treatments have been employed.

Most of the scientists of today agree that human beings, like all other animals, like to live in a state of equilibrium. Temperature, light, sound, food the condition of the mind, the inherited and acquired characteristics must be optimum to maintain the proper functioning of the body. When this homoeostasis is disturbed the body’s defenses try to restore the equilibrium. However, if the body is unsuccessful in its attempts, various forms of somatic and psychiatric disorders result.

Anthropological research has indicated “that mental disturbance occurs in every society, without exception, but varies in its frequencies of occurrence in different societies, hence, attention has turned towards a study of cultural factors which are associated with higher or lower prevalence rates for mental disorder” (Carstairs: 1976).

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.

Even in the twentieth century man’s attitudes and societal reaction towards psychiatric ailments continue to be asking to those of primitive man. In
the age of anxiety physical disease, famines and epidemics have of course been controlled to a great extent but the modern man’s existence has been plagued by a deeper kind of sickness- disbeliefs, disillusionments, doubts and depressions- to name only a few of many headed hydra of modern life. While the insane waves of wild materialism are still far off the Indian social scene, the teeming millions are yet to overcome the problem created by “the five evil giants”. The massive poverty and its allied for forces characterize the type of social milieu in which an average Indian lives and grows. The general backwardness deprivation, squalor, wants and monstrous economic insecurities may well be understood against the feudal, colonial background of the country (Brij Mohan: 1972).

In common parlance certain derogatory terms like “insane”, lunatic, mad and crazy are used to characterize mentally unhealthy person. In scientific terminology, however different phrases are used, viz., mental illness, mental disorder, mental disease, psychiatric ailments (or disorder or diseases) and the like. These labels cannote a negative state of human mind and behaviour. The positive concept, to be defined with in a cultural frame, is mental health. Both aspects are equally significant in psychiatry; the former is problem a later is goal (Brij Mohan: 1972).

Mental illness, to quote the Parson is “a state of impaired psychiatric functioning of the individual which is which is institutionally defined as not the individual’s ‘fault’ or responsibility, which exempt him from various ordinary obligations but which also institutionally described as an undesirable state” (Parsons: 1957). It includes the whole range of disturbance of human emotion, action, judgments and personality whenever this disturbance is sufficiently profound to be considered abnormal (Staffard: 1959). Mental illness is primarily manifest in behaviour and the term mental illness refer to a large number of disorders, some quite instinct from others and some merging, almost
Mental illness has somewhat the same range of connotation as does the term ‘physical illness’ (Clausen: 1963). In sum, mental illness means psychopathological sickness calling the psychiatric therapy. It may involve serious mental breakdown necessitating hospitalization or it may mean personality traits are quirks that lead to personal unhappiness. Mental illness can result in difficulty in getting along with others, and lack of ability to live a useful life (The World Encyclopedia: 1960).

**Mental Illness Through History:**

It has only been in the last 100 years that mental illness has been reached in a scientific way. Primitive people viewed mental illness as magic. One of their doctrines was that an evil being, such as the devil, could control the mind of a person. This is called demonology. The course of treatment was to exercise demons from the person by use of procedures, which were often cruel and barbaric by modern standards. If less painful techniques failed such as prayer, loud noises and foul odours, the person would be whipped and/or starved. One particularly crude practice was trephination in which the disturbed person’s skull was chipped away to allow demons to escape.

Ancient Greeks and Romans made a number of speculations about mental illness. They assumed that the cause of mental illnesses was a disturbance within the natural body itself (Foucault: 1973). Around 700 B.C the physician priest Alcmaeon hypothesized that brain processes caused sensation and concluded that difficulties in reasoning resulted from an illness of the brain. Hippocrates (460-367 B.C) stated that mental illness originated from an excess or imbalance among the four humor of the body. His classification of temperaments: choleric, melancholic, sanguine, and phlegmatic — corresponded to excesses in the four humors: yellow bile, black bile, blood, and phlegm, respectively. In addition, he believed that hysteria, a
disorder involving the loss of use of a body part, was a uniquely female disorder caused by a uterus, which wandered throughout the body.

Plato (429-347 B.C) departed from a purely physiological explanation and argued for the role of divine interpenetration. He described four kind of madness, two of which implied possession by good spirits. There were prophetic madness, such as Apollo’s oracle at Delphi, and poetic madness, which provided creative abilities. The other two types were erotic madness and ritual madness, which was induced by religious ceremonies. Aristotle (384-322 B.C.) revitalized Hippocrates’s emphasis on bodily functions. His theory, however, was far from progressive since he claimed that the heart is the casual agent in mental illness. Asclepiads (ca. 100 B.C) rejected the biological theory of Hippocrates and stressed the importance of environment factors. He differentiated between delusions, hallucination and illusions as well as acute and chronic onsets (Hayden: 1844).

Aretaeus (A.D. 30-90) is credited with the observation that mental illness is an exaggeration of the normal personality. He grouped illnesses according to pattern of symptoms, something that no one had previously considered.

In ancient Palestine mental illness was contacted with the supernatural. Little thought was given to medical or other aspects of mental illness in fact, there is some evidence that magical practices were designed to cast out the demons of madness as primitive people had done centuries before.

During the middle ages, treatment of mental illness was in the hands of priests who believed that demonic forces were at work in the mind of the affected. Consistently, they would sprinkle the disorder person with holy water and shout obscene epithets at Satan to hurt his pride. Actually two kinds of possession were recognized. In one form the person was unwillingly seized by the devil as God’s punishment for sins. These people were considered to be
mentally ill. In the second form, the person deliberately entered into a pact with the devil. These were witches with supernatural powers. By the end of the fifteenth century the distinction between two forms of possession was blurred, and many unfortunates were labeled as witches and accused of causing pestilence and floods. The actions by officials of the Catholic and Protestant churches furthered the belief in witches and prompted a multitude of arrests, hangings and other grotesque executions of suspected witches, many of whom were actually suffering from mental illness.

The Dutchman Johann Weyer (1516-1588) attached demonology to mental illness. He insisted that witches were ill and should be treated humanely. Although he formulated no theories of his own he was skilful in describing disorders well known today. He was particularly important in helping to counteract the barbaric treatment of mentally ill people who were constantly threatened with execution or expulsion from the community.

During the eighteenth century in Europe, the mentally ill were no longer killed or tortured as common practice. Instead they were chained and confined in jail with criminals. Although many feel that medical scientists were responsible for ending this practice, Foucault (1973) reports that the change was initiated by prisoners who were indignant at being forced to live with madman. The situation of the mentally ill was similar in the United States. By 1860, twenty-eight of thirty-three states had public asylums for the “insane” to keep them isolated from society. This was the reflection of the belief that the causes of mental illness were diseases of the brain that should be treated by physicians. In both the European prisons and the American asylums, the mentally ill were condemned to lives of misery and, in most case, permanent separation from society.

Humane treatment was initiated in France through the efforts of Philippe Pinel, a founder of modern psychiatry (1745-1826). Pinel invoked the concept
of individual freedom, made so salient in the France Revolution, in calling for reforms in treating the mentally ill. At the Bicetre Hospital, he removed patient’s chains, allowed them to access to hospital grounds and instructed the staff to employ human kindness. The results of his efforts were dramatic as many recovered who were considered incurable. Pinel’s reform movements were formalized at the Salpetriere hospital where personnel were trained to be more than custodians and were trained in keeping systematic records on each patient. Record keeping itself reflected the new belief that the mentally ill could be cured. But the policy of non-restraint, promulgated by Pinel and other reformers of the time, such as Tuke, was slowly adopted throughout the western world. Pinel’s ideas were tested in the United States largely through the efforts of Benjamin Rush (1745-1813) the father of American psychiatry. Rush, concerned with social reforms, introduced methods based on moral treatment at the Pennsylvania hospital.

Research in the late 1800 brought some empirical evidence to support the somatogenic hypothesis. Dementia paralytica, commonly known as paralysis, was discovered in 1798 among patients at the Bethlehem hospital in Pennsylvania.

During the somatogenic period, the first organized attempt at classifying mental illness was undertaken by Emil Kraplin (1855-1926). He observed that there were two major type of disorder. One was a disorder of mood expressed by excited behavior (mania) or melancholia behavior (depression), which he called the manic-depressive psychosis. The other disease involved a disorder of thought, often progressive, which he called dementia praecox since it resembled premature senility. It is now known as schizophrenia.

The casual link between psychological process and mental illness was first described by Sigmund Freud (1856-1939) who, with the assistance of Josef Breuer in the late 1800’s, studied the unconscious origin of psychological
difficulties, along with his theory that personality consists of three interdependent parts: the instinct (Id), the seat of moral regulations (superego), and the agent which functions to reach compromises between the parts of the personality and constraints of reality (ego), is often viewed as cornerstone of modern psychiatry.

Around the beginning of the twentieth century, many ideas were espoused which stressed the role of socio-cultural environment in the development of mental illness. During the 1880s as industrialization and urbanization was rapidly expanding, articles appeared in popular magazines pleading for Americans to wake up and avoid the loss of their moral fiber, which was being threatened by competitive jungle of modern industrial society. As early as 1844, C. D Hayden concluded, “[it is our] free institutions which promote insanity… life in our republic has all fearlessly join in the maddening rush for the laurel wreath…” (Blumer: 1893). Many more articles appeared articulating the theme that the engendered by modern industrial society had debilitating efforts on individuals. Before the turn of the century, Blumer (1893) the distinguished editor of the American Journal of Insanity, warned “Either the average brain of today has become a more unstable structure than the average brain of our ancestors; or else the average stress of the environment forces brought to bear on the brains of our generation has become more severe than formerly”. He believed that the alarming increase in the rate of mental illness in the United States was caused by the preoccupation of American with social mobility.

White (1903) suggested in 1903 that a return to a simpler life style was desirable. He felt that “…. Frontiersman who takes his family and goes west to open up new territory, engage in legitimate agricultural pursuits, and grow up with the country, is pretty apt. To be of hardy stock and insanity, if it appears at all, come in later generations”.
The twentieth century has been unlike any other century preceding it in the variety of concepts of mental illness. Some ideas of the past remain, such as belief based upon superstition or notion of the role of the devil. Other ideas however compete for attention and money. These ideas range from sophisticated biochemical research to psychoanalysis, behavior modification and community psychiatry to self help procedures embodied in techniques like bio-feedback and transcendental medication. All in all, these are at least two hundred therapies and numerous pseudo therapies available in contemporary western society, all intended to counteract psychological stress and behavioral abnormality. The most influential development in mental health during the twentieth century are the work of Sigmund Freud, the extensive use of psychoactive drugs and the community mental health movement.

Psychoanalysis was time consuming, expensive, and not particularly effective with seriously deranged patients like schizophrenia and psychotic patients. Its greatest gain had been with patients suffering from neuroses or chronic state of anxiety. But as psychiatry was again becoming stalled, it was rescued by the second twentieth century revolution in mental health, the discovery and use of psychoactive drugs to treat the mentally ill. Although the attempt to justify the medical model through theories of organic brain disease had failed, success came through the biochemical approaches. Now we turn to the history of mental illness in India.

**The History of Mental Illness in India:**

The history of psychiatry had witnessed three major revolutions that have given its resent status. First Revolution occurred when it was believed that sin and Witchcraft are responsible for mental illness and mentally ill were chained in jails & asylums. They were considered as out caste from society. Second revolution was the advent of psychoanalysis; that explained the etiology of psychiatric disorders. Third revolution was the development of
community Psychiatry that resulted in the integration of mental health care in the community.

Till about 17th century all abnormal behavior was believed to be act of the ‘devil’ i.e. ‘Against God’, ‘Mentally ill’ were considered evil and described as witches. Gradually over the passing time, mental illness was considered as ‘deviant behavior and mentally ill were considered socially unacceptable and put in jails along with other criminals. In the modern era, there is a shift from ‘evil’ to ‘ill. Mental disorders are represented in Ancient India in various types of literature. The aetio-genesis of these disorders was thought to be endogenous because of provoked humours like Vatonmad, Pitonmad and Kaphonmand. Exogenously the causes were attributed to sudden fear or association with ill influence of certain mythological gods or demon, Charak Samhita designated Psychiatry as Bhuta Vidya (Parker: 2001)

The description of personality is to be in terms of Sathvik, Rajasik and Tamasik representing intellectual and moral, emotional and passionatic and impulsive respectively and Tamsik is more or less near mental sub normality or angry. Treatment of mental disorders mainly included psychotherapy, physiotherapy, shock, drug treatment, hypnotism and religious discourses by Sages. Psychotherapy used to be in the form of talismans, charms, prayers and sleeping in temples with rituals. The indigenous manner of giving shock to the patient was terrorizing them by snakes, lions, elephant or men dressed as bandits. Then use of 10 to 100 years old medicated butter, drugs Cordfolia, horse radish (Shigru) with asafoetida and rock salt, centella Asiatic (Brahmi) with catechu and honey & powder of roots of serpentine were widely used. Najabuddin Unhammad (1222 A. D), an indian physician, described seven types of mental disorders viz. : Sauda-a-Tabee(Schizophrenia); Muree Sauda (depression); Ishk (delusion of love); Nisyan (Organic mental disorder); Haziyan (paranoid state); Malikholia-a-maraki (delirium). Psychotherapy was
known as *Ilaj-I-Nafsani* in Unani Medicine. ‘Siddhi’ means achievement and *Siddhas* are men who have achieved results in medicine, as well as yoga and tapas. The great saga ‘Agastya’, one of the 18 *Siddhas* has contributed greatly to the Siddha system of medicine of the South. He formulated a treatise on mental diseases called as ‘*Agastiyar kirigai Nool*’, in which 18 psychiatric disorders with appropriate treatment methods is described (Parkar: 2001).

In the last decade mental illness has been recognized as one of the most serious unsolved health problems facing by our country. A perusal of epidemiological research of mental illness in India reveals that contrary to opinions expressed by some people, it should be stated that the extent of mental morbidity in India is no less than that reported in the developed countries of the West. Considering the very large population of our country the figures for mental illness assume staggering proportions. Today mental illness stands among the leading causes of disease and disability in the world. One in four people in the world are affected by mental or neurological disorder at some point in their lives. World Health Report (2001) which was dedicated to the theme of Mental Health shows that these disorders are estimated to account for about 12 per cent of global burden of disease and also represent four of the ten leading causes of disability worldwide (Murthy: 2001). W.H.O estimates of 2001 indicate a prevalence level of about 22 per cent of individuals developing one or more mental or behavioural disorders in their lifetime in India. Wadhwa’s (2001) estimates that evaluation of the need comes nowhere near to the estimated 32 million Indian suffering from mental illnesses, including the 7 million affected by severe disorders.

In a meta-analysis of epidemiological studies in India by Reddy and Chandra Shekhar (1998) the prevalence of mental and behavioural disorder in India for urban sector is 80.6 per cent and it is 48.9 per cent for the rural sector. Illnesses like endogenous depression, mental retardation, all neurotic disorder
(except dissociative disorders) and behavioural emotional disorder were significantly high in the urban communities. More recently Ganguli (2000) has done an analysis of such studies. He has noted the national prevalence rates for all mental disorders, arrived at 70.5 (rural), 73 (urban), and 73 (rural & urban) per 1000 population. Urban morbidity in India is 3.5 per cent higher than rural rate. But it varies for different categories of disease. It is also noted that all the psychiatric facilities in the country are located in the cities and town serving predominately only 30 per cent of the urban population. The vast rural segments of the country comprising 70 per cent of the total population do not have any psychiatric facilities near their settlements. They have to travel long distance to approach the psychiatric centre or go without any help.

**Institutionalisation of Mentally Ill in India:**

During the reigns of King Ashoka, many hospitals were established for mentally ill. A temple of Lord Venkateswara at Tirumukkudal, Chingleput District, Tamil Nadu, contains inscription on the walls belonging to Chola period. The inscription mentioned a hospital and a school. The hospital was named as Sri Veera Cholaeswara hospital and contained fifteen beds. Maulana Fazulur-Lah Hakim, an Indian physician was in charge of the first Indian mental asylum, i.e. Mandu Hospital opened by Mahmood Khilji (1436-1469) at Dhar, M. P. First lunatic Asylum, Bombay Asylum, was built in modern India in approximately 1750 A. D. at the cost of 125/-, no traces of it is present today. In 1794, a private lunatic asylum was opened at Kilpauk, Madras. The central mental hospital, Yerwada, Pune was opened in 1889. First asylum for insane soldiers was started at Monghyr, Bihar and was known as Monghyr Asylum (1795) (Parker 2001).

Maxell Jones in 1953 introduced the concept of Therapeutic community resulting in the improvement in the Mental Hospital conditions. Subsequently other facilities such as occupational therapy, recreational facilities, outdoor
games and picnics were started in mental hospitals. Lt. Col. Berkley Hill was the pioneer in starting occupational therapy at the European Mental Hospital, Kanke, Ranchi, in 1935. However despite all these facilities, the adjustment of the mentally ill patients was poor in these hospitals (Bhattacharya and Chatterjee: 1978). After discussing the mental illness at global and particularly in India, we turn below to the mental health policy and programme in India.

**Mental Health Policy and Programmes in India:**

The development of psychiatric services in India, in contrast with economically rich countries has occurred against the backdrop of almost no mental health services at the time of Independence. Lunatic Asylum Act 36 of 1856 was modified to Indian Lunacy Act, of 1912. The enactment of Act resulted in opening of new asylums and improvement in the condition of asylums. The name lunatic asylum was changed to mental hospital in 1920. In 1946, the Bhore committee recommended changes in Indian Lunacy Act 1912, as it had become outdated. Indian Psychiatric Society formed in January 1947 quickly acted on the recommendation and a committee consisted of Dr. J. Roy, Major R. B Davis, Dr. Hasib was formed. It was finally enacted on 22nd May 1987.

Almost all people with mental disorders live in the community, most often do not have access to any organized services, with their family providing care in whatever form it is able to do (ranging from isolation to committed care). At the time of Independence, the mental health infrastructure and specialist manpower was meagre. In 1947, India had 10 000 psychiatric beds for a population of over 300 million, compared to the United Kingdom, which, with one-tenth the population of India, had over 150 000 psychiatric beds. During the past six decades, wide ranges of mental health initiatives have changed the situation. These efforts to address the needs of mentally ill persons and their families have been continuous and innovative, building on the
strengths of the community. The first two decades of independent India were devoted to doubling the number of mental hospital beds and humanizing the services at hospitals (Dube: 1963, Sharma: 1990). Interestingly, one of the most important innovations occurred in a mental hospital setting—the active involvement of families in the care of mentally ill persons. This initiative, started in Amritsar by Dr Vidya Sagar, was far ahead of the times as in the rest of the world, at that point, families were considered ‘toxic’ to the mentally ill and were not involved in the care of the mentally ill (Vidyasagar: 1973). This was followed by the setting up of general hospital psychiatric beds, which was ‘a slow and silent change but in many ways a major revolution in the whole approach to psychiatric treatment in our lifetime’ (Wig: 1978). The next major development was in 1975, when a new initiative to integrate mental health with general health services, also referred to as the community psychiatry initiative, was adopted to develop mental health services (Murthy et al: 1977). Community psychiatry in India is now nearly 4 decades old. Starting as an isolated extension of psychiatric clinics in primary health centres, today the integration of mental healthcare in general services covers over 127 districts (about 20% of the population). The National Mental Health Programme (NMHP) was formulated in 1982 to develop a national-level initiative for mental healthcare based on the community psychiatry approach (Srinivasa: 2000). During the past three decades, there have been a large number of other community initiatives to address a wide variety of mental health needs of the community through programmes on suicide prevention, care of the elderly, substance use and disaster mental healthcare, and by setting up of daycare centres, half-way homes, longstay homes and rehabilitation facilities (Ranganathan: 1996). The rapid growth of psychiatry in the private sector is another important recent development. Though mainly confined to large urban centres, private sector psychiatry is providing valuable services to the community (Murthy: 2011).
General Hospital Psychiatry Units (GHPUs):

In contrast to western countries, where GHPUs work with the support of mental hospitals, in India, most GHPUs provide a wide range of services fairly independently. This is in many ways a major revolution in psychiatric treatment (Wig: 1978). At present, most medical college hospitals and major hospitals have psychiatry units. This has had twin advantages, namely, the services come closer to the population and services can be provided in a non stigmatizing manner. It is also important that in India these units have become centres of research and manpower development.

National Mental Health Programme (NMHP):

The need for setting up of district psychiatric clinics was recognized in the 1960s by the Mudaliar Committee (Mudaliar: 1962). A few centres did come up following the report of the committee. However, the important national-level initiative followed the discussions of the Indian Psychiatric Society at Madurai in the early 1970s, which voiced the need to integrate mental healthcare with general healthcare. Simultaneously, in 1975, the Expert Committee on Mental Health of the WHO published a document titled ‘Organization of mental health services in developing countries’ (WHO: 1975). The ideas generated in these discussions and documents were put to test at NIMHANS, Bangaluru and Postgraduate Institute of Medical Education and Research (PGIMER), Chandigarh, which took up pilot programmes to integrate mental health with general health services during the 1975–81 period (Murthy: 1978). The experiences of these two centres supported the development of the NMHP.

In the 1980s, the Government of India felt the need to evolve a plan of action aimed at the mental health component of the national health programme. For this, an expert group was formed in 1980. In February 1981, a small drafting committee met in Lucknow and prepared the first draft of the NMHP.
This was presented at a workshop of experts (over 60 professionals) on mental health, drawn from all over India, in New Delhi on 20–21 July 1981. Following the discussion, the draft was substantially revised and a new one was presented at the second workshop on 2 August 1982 to a group of experts from not only the psychiatry and medical streams, but also education, administration, law and social welfare. The final draft was submitted to the Central Council of Health, India’s highest health policy-making body, at its meeting on 18–20 August 1982, for adoption as the NMHP for India (DGHS: 1982). The Council discussed this programme at length and adopted a resolution for its implementation in the states and union territories: ‘Mental health must form an integral part of the total health programme and as such should be included in all national policies and programmes in the field of health, education and social welfare. Realizing the importance of mental health in the course curricula for various levels of health professionals, suitable action should be taken in consultation with the appropriate authorities to strengthen the mental health education components. While appreciating the efforts of the Central Government in pursuing legislative action on the Mental Health Bill, the joint Conference expressed its earnestness to see that the bill takes a legal shape at the earliest.’

The objectives of the NMHP were: (i) to ensure the availability and accessibility of minimum mental healthcare for all, particularly to the most vulnerable and underprivileged sections of the population, in the foreseeable future; (ii) to encourage the application of mental health knowledge in general healthcare and in social development; and (iii) to promote community participation in the development of mental health services and to stimulate efforts towards self-help in the community.

The approaches advocated by the NMHP were: diffusion of mental health skills to the periphery of the health service system; appropriate
appointment of tasks in mental healthcare; and integration of basic mental healthcare into general health services and linkage to community development and mental healthcare. The service component included three sub-programmes—treatment, rehabilitation and prevention.

Looking at the NMHP document of 1982, three decades later, one can say that its main strength was the envisaged integration of mental healthcare with general primary healthcare (Agarwal: 2004). However, there were some inherent weaknesses in this otherwise sound conceptual model. The entire emphasis was on curative rather than preventive and promotive aspects of mental healthcare. Community resources such as families were not accorded due importance. Ambitious short-term goals took precedence over pragmatic, long-term planning. Most glaringly, no estimate, leave aside provision, of budgetary support was made. The administrative structures needed to implement the NMHP were not clearly outlined. These deficiencies possibly contributed to the limited progress seen for nearly a decade after the formulation of the document. Since its adoption, the NMHP has been the guiding document for the development of the mental health programme in India. The most important progress has been in the area of development of models for the integration of mental health with primary healthcare, in the form of the district mental health programme. The DMHP, developed during 1984-90, was extended initially to four states, then to 25 districts in twenty states during 1995–2002 and over 125 districts in the next seven years. The other areas that received support in the NMHP included improvement of departments of psychiatry at government medical colleges, development of human resources and improvement of mental hospitals. There is an acute shortage of manpower in the field of mental health, namely, psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses. This is a major constraint in meeting mental health needs and providing optimal mental health services to people. The existing training infrastructure in India
produces about 320 psychiatrists, 50 clinical psychologists, 25 psychiatric social workers and 185 psychiatric nurses per year. Due to the shortage of manpower in mental health, the implementation of the DMHP suffered in the previous plan periods. During the Eleventh Five-Year Plan, there has been a substantial increase in the funding support for the NMHP.

The implementation of the DMHP is the most important public health initiative in mental health and has a direct impact on the needs of persons with mental disorders living in the community. At the national level, the DMHP is in operation in 127 districts.

The DMHP has the following objectives:

1. To provide sustainable basic mental health services to the community and to integrate these services with other health services.
2. Early detection and treatment of patients within the community itself
3. To see that patient and their relatives do not have to travel long distances to go to hospitals or nursing homes in the cities
4. To take pressure off the mental hospitals
5. To reduce the stigma attached to mental illness by promoting a change of attitude and through public education
6. To treat and rehabilitate mental patients discharged from mental hospitals within the community.

Community Level Mental Health Services:

Two activities are required to address the needs of the community. First, systematic studies are needed to evaluate the community intervention initiatives for mental health. The second is the setting up of community-level facilities, largely by voluntary organizations.
Four studies have addressed the situation of persons who suffer from schizophrenia and live in the community, and the effectiveness of community-level interventions (Venkatesh et al.: 2008). These studies show the benefits of regular treatment in decreasing the patient’s disability, the burden on the family and the costs incurred by the family. These studies also emphasize the need for community involvement in the care programmes.

Another important development over the past twenty-seven years is the availability of a wide variety of community care alternatives, essentially from the voluntary sector (Ranganathan: 1996). These initiatives have included the establishment of day care centres, half-way homes, long-stay homes and centres for suicide prevention, and also address care of the elderly, disaster mental healthcare, and school and college mental health programmes. All these have been accepted by communities, suggesting the need for such community care services. Such services, when provided in a user-friendly manner, are more likely to be used by the public. However, there is an urgent need to consolidate the experiences of the work in this area, in terms of the needs of those who seek help from these facilities, the nature of interventions, the outcome of care, the needs of the staff and human rights. There is also a need to develop mechanisms to meet the demand for institutional care, to standardize the norms for setting up of these facilities and to develop mechanisms to ensure the human rights of persons receiving care from these facilities. The availability of a wide variety of both medical and non-medical care models is another development in the past two decades. Specifically, the growing role of non-governmental organizations (NGOs) which provide services for suicide prevention, disaster care and school health programmes, in which non-specialists and volunteers play an important role, has tremendous importance for India as NGOs can bridge the gap of human resources.
Mental Health Policy:

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.
Review of Literature:

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. We have tried to review the existing literature on mental illness from sociological point of view at global and at Indian level.

Ruth Benedict (1934) made the first clear statement of the effect of culture upon abnormal behaviour; and one of her students, Margaret Mead was the first American anthropologist to organize research along psychiatric lines. Benedict showed that Melanesian society is built on traits, which would be regarded as paranoid in a western culture. The members of the groups look upon on another as purveyors of "black magic", and the women would never think of living their cooking pots unguarded. The extent of the paranoid thinking is seen in the standard polite phrase of acceptance of a gift, “And if you now poison me, how shall I repay you for the present” (Benedict: 1934).

In 1961, Goffman wrote *Asylum*, which described life inside state mental hospitals. Goffman indicates that mental hospitals are total institutions, (other total institution are prison, boot camps monasteries and convents). In a total institution, a resident is cut off from society for appreciable periods of time and required to lead a regimented life. Inside an asylum, residents are stripped of their clothing and deprived of contact with the outside world. Total institutions seek to control residents fully and re-socialize and remake their lives. The fear of expulsion is often a major control mechanism. Long-term
confine in asylum usually cause people to lose their capacities to respond in an independent rational fashion and undermines their ability to cope with the outside world. Total institutions teach residents to accept the staff’s view of right and wrong, eroding residents’ capacities to think independently. Such actions as questioning the therapeutic value of treatment programs are taken not as sign of mental but as symptom of sickness. The “good” patient from staff’s point of view, is one who is understanding, docile, and obedient. In general, mental hospitals downgrade patients’ feeling of self-esteem and emphasize their failures and inadequacies. Uniform furniture and clothing, a regimented routine, and a custodial atmosphere encourage patients to be docile and unassertive. The use of medical model approach to emotional problems encourages patients to view themselves as sick and in need of help. Such “re-socialization” actually hinders residents from making a successful return to society. There is a high probability that long term hospitalization will do more harm than good.

Scheff (1966) in his book “Being Mentally Ill: A Sociological Theory” discuss one of the most important sociological statements regarding the causes of mental disorder that adopts the labelling perspective. Scheff argues that mental disorder reflects learned role behaviour and that the reactions of others are critical to the assumption of that role.

Deb (1997) in his article ‘Mental Disorder in Adults with Mental Retardation and Epilepsy’ studied the rate of mental disorder in 150 adults (aged 20-77 years) with mental retardation and epilepsy among the residents of a health district of the United Kingdom who lived either in institution or in the community, and compared them with an age, sex, and Intelligence Quotient matched non-epileptic adult mentally retarded population from the same institution and community. Mental disorder was assessed under three headings
namely severe maladaptive behaviour, psychiatric illness and personality disorder.

Laine and Lehtinen (1973) in their article “Attitudes towards Mental Illness and their Relationship to Social Structure and Mental Hospital Bed Utilization in Two Finnish Rural Communities” analyzed on the basis of Durkhiem’s and Allardt’s theories of social structure. One community was mainly agricultural (community A) and other was industrialized (community B). It made use of a likert-type attitude scale created for the purpose, and the personal interview technique is used. The sample consisted of 200 individuals and the response percentage is 94. The main hypothesis of the study, introduced on both sociological and psychiatric grounds, was that attitude in community A would be more negative than in community B, but results failed to confirm this. On the other hand, men’s attitudes were more positive than those of women in both communities, but to a statistically significant only in community B. Moreover, age and sex correlated with attitude in this community’s attitudes were more positive, the older a man and the younger a woman. When age was considered singly and as a continuous variable it did not, however, correlate with attitudes. A positive association between attitudes and educational levels was observed in both communities, and the same was true of the number of sources of information about mental illness and attitudes. Laine and Lehtinen state that attitudes may be considered as intervening variable and that no far reaching conclusions concerning causal relationships can be based on them.

Hagnell and Hansson (1996) in their article “Epidemiology of Mental Disorders in Sweden” review some prominent features and results of research in the field of psychiatric epidemiology in Sweden. The interest in doing epidemiological research has grown from an interest in genetics, an interest in social, psychiatric issues and a need to investigate the epidemiology of mental
illness from the perspective of needs for care and planning of resources for psychiatric services.

Meeks and Murrell (1997) in their article ‘Mental Illness in Late Life: Socio-economic conditions, Psychiatric Symptoms and Adjustment of Long Term Suffers’ examined the relationship between social and economic conditions and psychiatric disorder among 346 older adults with severe mental illness living in the community. Measures included socio-economic indexes, symptoms, diagnosis and adjustment. As expected, socio-economic and illness factors were interrelated in this sample. Diagnosis was related to both functioning and socio-economic factors.

Banerjee (2007) in her book “Foucault’s Analysis of Mental Illness” analyses the mental illness from the Foucaullion perspective. His book “Madness and Civilization” (1961) is a text, which addresses the question of historical condition of emergence in the course of seventeenth century of a distinction between reason and unreason and madness. Madness and Civilization describes how the insane were singled out as a separates from among the heterogeneous mass of beggars, vagabonds, whores, robbers cripples, invalids etc., who a hundred year before had been the object of the “great incarceration” in hospitals, workhouses and correctional facilities throughout Europe. Towards the end of eighteenth century, lunatics were given their own institution: the asylums. The French physician Philippe Pinel was a great humanist. It was he who freed the lunatics from their chains in Bicetre Hospital in 1794. The change in treatment and practice associated with the birth of the asylums have undoubtedly been regarded as symptomatic of both humanitarian reform and medico scientific progress.

Vijayalakshmi (1978) in her article “Study of Factors Affecting Chronocity in Mental Patients” discusses the problem of chronocity among mental patients. The chronocity persisted inspite of many innovations in patient
care. While the hospital has the greatest amount of former power to determine the discharge, medical considerations are often overshadowed by social and interpersonal factors. Twenty-eight per cent of patients in the hospital under study are found to be staying in the hospitals of more than two years. The factors found to be significantly associated with long stay of these patients in the hospital are advanced age, lower-income, distant location of native place from hospital, certified type of admission, dependency, unemployment and absence of visitors during their hospitalization.

Desai (1973) in his article ‘New Approach to Tackle Nation’s Mental Health Problem’ discussed a new approach to tackle a nation’s mental health problem. He points out the influence of family system bearing on mental health, connected with family structure, increasing urbanization, economic development and industrialization and population mobility. While suggesting preventive steps states that harmful circumstances must be identified and counteracted before they have had a change to produce illness and disorder. Preventive programmes at the primary level must promote the social, emotional and physical well being of all people. He mentioned some of the most pressing psychiatric problem in our country.

Murthy (1977) in his article ‘Rural Community Attitude to Mental Disorders: Preliminary Findings’ has taken hundred adults from 100 houses of a village in Haryana. Perception, seriousness, treatment and prognosis about mental illnesses are discussed. It is observed that their information about psychosis is correct about minor ailments.

Kazi, Kavitha and Shariff (1993) in their article ‘Indicators of Social Supports in the Families of Mentally Ill Belonging to Scheduled Caste’, analyses the types and sources of support available to mentally ill patients. The analysis of results indicated that seven indicators of social support are joint
family system, married status, first born, long duration of illness, education of
patients, being males and elderly patients.

Valdiya, Chaudhary and Augustine (1992) in their article ‘Psychosocial Stress and Psychiatric Morbidity’ aimed at examining psycho-social stress in day-to-day life of men in uniform. The sample of study constituted 1368 patients admitted in psychiatric wards. Observations revealed that 43.93 per cent were diagnosed for neurosis, 27.48 per cent for psychoses and 3.87 for other. The stress factor, which is most common in these, is domestic stress followed by service stress and physical factors.

Rahman and Firoz (1999) in their article ‘Childhood Abuse and Psychiatric Disorders – A Study of 121 Cases’, is taken over a period of one month who admitted different forms of abuse in their childhood. The study has generated the chance of large-scale study about rates of different type of childhood abuse among the general population and psychiatric patients. The vulnerable group in childhood appears to be the depressives specially the female people from middle class origin with rural background and those who have middle grade education.

Pathen, Kuruvilla et al. (1999) in their study ‘Risk Factors Associated with Common Mental Disorders in Rural Tamil Nadu’ aimed to determine the risk factors associated with common mental disorders in rural Tamil Nadu. Consecutive patients attending a primary care general health clinic that fulfilled eligibility criteria is interviewed with the revised clinical interview schedule to detect common mental disorders. Risk factors are assessed using a special Performa. The ICD (International Classification of Diseases) top criteria for primary care is used to make a diagnosis. Risk factors associated with the development of common mental disorders is inability to buy food because of lack of resources, age, gender, recent bereavement, number of children, employment, marital status, physical diagnosis, past psychiatric illness,
residence and visit to traditional healers is not associated with an increased risk. Mental disorder Illiteracy and poverty are found as risk factors for common mental disorders in rural Tamil Nadu.

Gupta et al. (1999) in their article ‘Knowledge, Attitude and Beliefs about Mental Illness’ discusses knowledge, attitude and beliefs (KAB) about mental illness, which play a significant role in determining help seeking behaviour and compliance among the patients with mental illnesses. Attitude towards mentally ill individuals influences the social support and empathy received by mentally ill in the society. The utilization and impact of mental health services and the degree of community participation depend on the KAB of the people in society. Thus it may be useful to have periodic assessment of the KAB of various individuals in a community and to take corrective educational measures of necessity. It was found that many of the students had misconceptions about mental illness and perceptions about the effect of mental illnesses, few of them had negative attitude towards mentally ill. The results are compared with KAB of family members of the mentally ill patients.

Malhotra et al. (1992) in their article ‘Life-events in Psychiatically Sick Children’ discuss some studies to suggest that the effects of life-stress on children and adolescents may be similar to those found in adults.

Bhatti and Channabasavanna (1986) in their article “Study of Neuroses: Family Interactional Patterns and Social Variables’, have observed that neurotics come from higher income joint families. They also had dissatisfaction from their occupation, income and status in the family and have unhealthy interaction patterns in the family of orientation as well as procreation. Discriminant analysis shows that the tools used in this study have predictability.

Ramachandran, Menon and Ramamurthy (1981) in their article ‘Family Structure and Mental Illness in Old Age’ studied a random sample on subjects
aged out 60 in the community. Out of 181 subjects studied, 50 are found to suffer from functional disorders such as depression and anxiety, and 11 from organic brain syndrome, 120 are found psychiatrically normal. Over 50 per cent of the elderly subjects studied are widowed and about 70 per cent are employed and nearly 80 per cent belonged to lower middle class and low socio-economic groups. The families of the elderly persons and their living conditions are studied in detail. The family is divided into joint, nuclear and loosely joint on the basis of living arrangement, financial support and other help they received. Functional disorder is found high in old age persons living in nuclear family and living alone. 33 psychosocial variables affecting the health of the elderly persons are studied and their correlation to psychiatric illness is determined. Further, factorial analysis is carried out and three factors were extracted. Hence it is found that the family and living conditions are significant factors affecting the mental health of the elderly persons. The aim of the study is to examine the family structure and family cohesion of elderly persons in the community and to examine its relationship with emotional disorders.

From the above-mentioned studies, we can conclude that not much attention has been paid to the comprehensive study of mental illness, which include the etiology, treatment process and societal reactions towards the mentally ill people. Moreover, the study of mental patients by the large remains unexplored. Hence the importance of the study of mental patients becomes very important because individual lives and reacts in a social environment. In this study attempts has been made to examine and investigate the socio-economic, cultural variables, which affects the mental patients and their interpersonal relationship with the families. The foregoing history of mental illness different policies and programmes of mental health in India suggest that the conceptualization of mental illness has undergone with several
transformation. Thus, it becomes pertinent to conceptualize mental health and mental illness in the present context.

**Concept of Mental Health:**

The very conception of mental disorder of abnormal behaviour involves an understanding of its normal counterpart, 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.

**Concept of Mental Illness:**

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.
Mental illness is a very vast discipline, broad in its limits and more difficult to define precisely than the colours on a mountain at sunset. Mental disorder, to quote Parsons (1957), is “a state of impaired psychiatric functioning of the individual which is institutionally defined as not the individual’s ‘fault’ or responsibility, which exempts him from various ordinary obligations but which is also institutionally described as an undesirable state.” It “Includes the whole range of disturbances of human emotion, action, judgement, and personality, whenever this disturbance is sufficiently profound to be considered abnormal” (Staffard: 1959).

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.

Mental illness has been recognised as one of the disabilities under Section 2 (i) of the person with disability (Equal opportunities, Protection of Rights and Full Participation) Act, 1995. Mental illness has been defined under Section 2(q) of the said Act as any mental disorder other than mental retardation.

Mental illness is an outcome of factors underlying in the given social structure of society, thus, below we will discuss social structure and mental illness.
Social Structure and Mental Illness:

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.
Substantial evidence now confirms the relationship between poverty and socio-economic inequalities for both common and severe mental disorders. In United Kingdom, for example, there is good evidence for an association between low standard of living and depression (Weich and Lewis: 1998). There is some evidence that cities, particularly inner city areas have a higher rate of mental illness than rural areas. This finding may be due to deteriorated quality of life, dirt, noise, crime, transportation problem, inadequate housing, unemployment etc. which creates a higher level of emotional problems (Harphan and Blue: 1995). People who are single, divorced or widowed have higher rates of mental disorder than married people. Married adults have lower level of depression and anxiety compared to those who are single (Shepard and Harwin: 1978). Quite and contrary kind of threat to mental health is posed by those jobs which call for heavy demands on the worker’s time and emotional energy. A study of Buck for the employees of one American company found that working under pressure was related to job dissatisfaction for both managers and workers and was related to poorer mental health. Study of Odegaard is pioneering study of Norwegian Migrants in America found high rates of schizophrenia among the men. To some extent this might have been due to self selection, the more disturbed individuals moving away from their native community. The conditions migrants find are also likely to affect their health. The same study concluded that social factors in the new environment-specifically poor housing condition-probably contributed to the high rate of senile psychosis among immigrant women. Gender is a crucial element in health inequities in developing countries. Gender influences the control men and women have over the determinants of their health, including their economic position and social status and access to resources and treatment. The female excess for depression has been demonstrated in most community-based studies in all regions of the world. The social gradient in health is heavily gendered, and women are disproportionately affected by the burden of poverty
that in turn, may influence their vulnerability for depression. Women are far more likely to be victims of violence by an intimate partner are significantly more likely to suffer depression, drug abuse or attempt suicide (Patel et al.: 1999). The social consequences of low education are obvious, especially in developing countries that facing a growing lack of security for employees as economies are reformed. Lack of secondary education may represent a diminished opportunity for person who is depressed to access resources to improve their situation (Patel et al., 1999). The lack of social support and the breakdown of kinship structure is probably the stressor for the millions of migrants labourers in the urban centres of Asia, Africa, and South America, as well as the millions of dependents who are left behind in rural areas and whose only hope of survival is the remittance relatives send from distant cities. In developed countries, increased mobility of labour has reduced family ties and also led to the decline of the extended family (Patel et al., 1999).

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.

Merton (1957) conceived of anomie as “the state of confusion” which leads to disorders in the value systems of a society. The direct consequence of the crisis in the value-system is “the marked anxiety” that most individuals suffer in present-day societies. This view of Merton on anomie leads to two possible conclusions regarding mental health problems. The first is that the exposure to negative conditions such as confusion or disorder (as opposed to order) can result in mental health problems for individuals (Agnew: 2002; Pearlin et al.: 1981). The second is that the disequilibrium between expectations and actual achievements can also have an adverse effect on individuals’ mental health (Agnew: 2002).
Like Durkheim, Merton also formulated five typologies resulting from the differential levels of variation between goals and the avenues to reach them. In other words, the typology of modes of individual adaption of Merton corresponds to the different levels of disequilibrium or equilibrium between cultural goals and institutionalized means. The first mode of adaption, or conformity, is the result of a match or equilibrium between societal goals and institutionalized norms. The second is innovation which refers to the individuals who score positively on cultural goals but negatively on the institutionalized means. The third type of adaptation is ritualism, which is exactly the opposite of innovation. Ritualists score negatively on cultural goals and positively on institutionalized means. The fourth type, retreatists, is the opposite of the conformists because retreatists reject both cultural goals and institutionalized means. The fifth and the last one is the rebellion. Rebels are peculiar cases because they score negatively on both cultural goals and institutionalized norms.

A third modern sociological theory that deals with mental illness is the conflict theory of Karl Marx. In his “Communist Manifesto”, Marx (1848) argued that the history of humanity is the history of class struggle (Marx and Engels, 1845). This struggle is between the oppressors and the oppressed. The oppressors are the class of the bourgeoisie and the oppressed, the proletariat, are members of the working class. The bourgeoisie is constituted of individuals who exploit the working class in order to get wealthy. As result of this exploitation, there is a power difference between the bourgeoisie and the proletariat.

More precisely, the bourgeoisie owns the means of production and consequently is economically, politically, and socially advantaged compared to the proletariat. The differential level of status between the bourgeoisie and the proletariat has been used by sociologists to explain the high prevalence rate of
mental illness among individuals with low socioeconomic status (SES) compared to those with higher SES (Breslau et al.: 1982; Eaton and Muntaner: 1999; Emerson: 2003; Hastings: 2002; Horwitz: 2002; Hudson: 2005; Simon: 2000). The conflict theory has also been helpful in explaining the differential vulnerability between individuals at the subordinate position relative to those occupying higher positions.

Gender difference in mental is another area in which the conflict theory is applied. The conflict theory helps sociologists to understand why women experience higher levels of mental health problems compared to their male counterparts (Horwitz: 2002; Mirowsky and Ross: 2003). To explain this gender difference in mental health, researchers analyzed the distribution of power between men and women within the household. Women are often associated with lower status compared to men. This observation leads to the notions of dominated and dominant. Given that men are for the most part the dominant figures and the women the dominated figures in the household, it is clear, through Marx’s theory, that the latter will suffer more mental health problems than the former (Rosenfield: 1999). Being in the dominant position, men have the proclivity to vent their frustration toward the dominated (women) (Mirowsky and Ross: 2003).

A fourth modern sociological theory of mental health is the labelling theory of Scheff (1999), which is derived from the study of deviant behaviours. According to Scheff the concept of deviance is related to the notion of rules or norms. In general, society spells out accepted and unaccepted norms. This organization of the society allows rewarding individuals who conform and punishing those who do not. One way to punish individual rule-breakers is to label or stigmatize them. However, labelling the individual rule-breakers will lead to more and severe rule-breaking. From this perspective, Scheff postulates
that the societal reaction to rule-breaking is contributing to the worsening of the problem of deviance.

Scheff applies this labelling theory to the area of mental health. In fact, Scheff considers mental illness as deviant behaviour and consequently defines it as rule-breaking. However, unlike most deviant behaviours, mental illness is non-conformity to the residual rules. For him, residual rules are norms that are not explicitly classified as either prescribed or proscribed. They are, instead, norms or rules that are taken for granted and to which society does not have specific labels. An example of rule-breaking might be conversing with a spirit by an unqualified individual (e.g., an individual who is not a religious figure or medium) under inappropriate conditions in the United States. Other illustrations of residual rule-breaking might be hallucinations and continual muttering (Scheff: 1999).

**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 becomes 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.