

Triple Burden of Mental Illness on Women: Illness, Stigmatization and Abandonment

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Abstract: *Women perform both productive and reproductive roles in the society. They form the backbone of the care economy. The women with mental illness form a vulnerable section of the society. The social construct of stigma has rendered women helpless without any respite. There is a rise in the instances of abandonment of the mentally ill women. With no acceptance in the society, their population is on the rise among the destitute. This article deals with the reasons as to why the population of abandoned mentally ill women is on the rise? Also, despite a long-lasting mental health program and legislation, why rehabilitation of these women is not being done? The article also critically reviews the provisions of Hindu Marriage Act, with respect to persons with mental illness. Policy gaps have been identified and recommendations for future have been presented.*

Keywords: Mental Health, Stigma, Gender Analysis, Mental Healthcare Act-2017, Rehabilitation

1. Introduction

Mental health is a critical aspect of life and its importance is reflected by its inclusion in WHO definition of Health. Persons suffering from mental disorders are the vulnerable population of the society and more so are the women who suffer from mental illness. With a patriarchal mindset of society, the women are considered weak and powerless. With the existing prejudices, her capabilities are doubted. A woman has to suffer from the Triple Burden of Illness, Stigmatization and Abandonment. Mental Illness affects the social, economic, cultural, environmental and biological aspects of life. With the compromised capabilities of a person with mental illness, isn't there more of a reason to provide for them? They need to be included in the welfare. Affirmative actions for their rehabilitation and resettlement are imperative to provide them a social standing and a healthy fruitful life. This article takes through the issues of women suffering from this triple burden, why have they driven to destitution and is this only answer for them? It is not that the country does not have programs and policies in place for person with mental illness. Then why have these policies not achieved their goals? Why the policies lag behind in providing rehabilitation to this section of society?

Mental Disorders

"Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviours and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse" (WHO). Mental health problems affect 450 million people worldwide, 80% in middle-income and low-income countries. Mental health conditions account for 13% of the total burden of disease (Trani JF, 2015). WHO predicts that 20% of the Indian population will suffer from mental health illness by the year 2020. In India, the prevalence of mental disorders ranges from 10 to 370 per 1000 population in different parts of the country. The rates are higher in females by approximately 20-25% (Vajpayee J and MakkarK, 2014). Gender is a critical determinant of mental health and mental illness. The

gender acquired risks are manifold and interconnected. "Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risks" (WHO). The women suffer more with common mental disorders like depression, anxiety and somatic complaints. As per WHO, depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men. Women have higher rates of suicide attempts and post-traumatic stress disorder than men (WHO). Even though no gender differences in epidemiology of disorders like schizophrenia have been reported, the homeless women experience higher rates of sexual and physical victimization, and more anxiety, depression and medical illness than men. Gender manifests in course, prognosis, diagnosis, treatment of disorder, care seeking behaviour and utilization of services.

2. Abandonment of Women with Mental Illness

A woman of 30 years of age with chronic mental illness, institutionalized, found pregnant due to rape, left to fend for herself and her child. After constant escapes from the institution she lost her child, suffered more physical and sexual abuse and now lays bed ridden due to road traffic accident with no hope for the future (Gajendragad JH 2015). Another patient started exhibiting psychotic symptoms after the father's death and was admitted to the institute 10 years ago. The mother still sends a box of sweets every Diwali through the driver. A 68-year-old woman spent 30 years in the ward. No one came to her funeral (Kapoor C. 2017). These are just a few handful tragic stories of women suffering from mental illness and institutionalized in Institute of Human Behaviour and Allied Sciences (IHBAS), New Delhi. But there is a large section of such abandoned women who face these issues and live their lives with no hope for respite. Women are becoming the fastest growing population in the homeless. It is estimated that of the 10 million affected populations about 50,000 to 1 lakh are

homeless. The city of Delhi has about 3000 mentally ill women who are on the streets and have nowhere to go. Extrapolating for the whole nation, the country has nearly 150,000 mentally-ill destitute women (Report on National Seminar on Mentally Ill women- Is Destitution the only Answer). With limited access to the mental health services for the women they become street dwellers and suffer major physical, mental and sexual abuse. They are lost and treated as non-persons, consciously ignored and paid no attention. (Gajendragad JH 2015).

Reasons for Abandonment

To understand that why these women are abandoned, the social constructs of Stigma and marriage play major role. Along with, it is imperative to understand why the policies have not been able to provide respite to these women and why inclusive growth and development not been witnessed for this vulnerable population? The women are either left at treatment homes, forgotten or are left as street dwellers without acceptance back at home. Either way they end up on street, without any security and form a major portion of the homeless population. The major contributors are social construct of Stigma and loopholes in the Marriage laws.

• Stigma

People who suffer from mental illness are the most discriminated against, stigmatized, marginalized and vulnerable group of the society. Being a woman thus thrusts upon them additional burden of abandonment. Studies have found that the mental illness is considered as a taboo and women labelled as witches or thought to be under the influence of spirits. Additionally, are taken to local doctors, quacks, religious leaders in the rural India only adding to their woes (Basu S, 2012). The mental illness is hid by the parents as the prospects for marriage may lessen for their daughters. The responsibility of being mentally well is thrust on the womenfolk against the social reality that it rarely lies in their hands (Davar BV, 1995). The stigma of being separated or divorced is faced more by the women than the stigma of mental illness (Narayan CL, et al 2015)

• Marriage

Marriage is a social construct governed by the Indian laws of Hindu Marriage Act and Special Marriage Act. The Acts for marriage and divorce contain certain measure which stigmatizes mental illness and act as ground for divorce, compromising the human rights of the women. The use of Unsoundness of mind reinforces stigma. A mental disorder has been used as a general term which can include minor to severe forms. This has been used for filing of divorce. As per the Act, when sterility is not a ground for divorce then why is inability to procreate as a result of mental disorder considered for divorce. Also, it is rarely that a psychological disorder leads to procreation issues. Recurrent attacks of insanity form grounds for nullity of marriage but the disease can range from simple mood disorders to psychosis. While the disorders are now curable, why such clauses still remain valid? It is unfair to put a restriction to the persons with mental disorders to marry as marriage is a human right and under the pretext of mental disorders, the rights of the women are majorly hampered. Meanwhile these clauses make the stigmatization stronger. The women are ostracized and left to fend for themselves (Malhotra S. and Shah R.,

2015). The women have to provide the care role in this patriarchal society if the husband is ill. They continue with their productive and reproductive roles. (Narayan CL, et al, 2015). At the same time a woman with mental illness is victimized, ignored and her human rights are violated. She is not taken for consultations and provided appropriate medical care. Health seeking behaviour is low due to superstitions, lack of education and reluctance (Davar BV, 1995). It is a potent barrier to treatment seeking and imposes substantial cost to individual and society (Wirth JH and Boodenhausen GV, 2009). They also face the tragedy of being left at institutions with false address and names and no one ever comes back to pick them and they spend decades there (Gajendragad, JH, 2015).

• Lack of rehabilitation

Very often the question has been raised that is destitution the only answer for these women? The rehabilitation of the mentally ill women has been a major challenge. Government of India has been implementing National Mental Health Program (NMHP) since 1982. This was further expanded to the District Mental Health Program. By the end of 2012 the plan was expanded to 200 districts of the country. Lack of IEC programs to fight stigma, shortage of human resources, lack of accountability, more focus on curative services rather than the preventive ones and few provisions for the rehabilitation of the discharged patients reflected the consistent disparities in achievement of objectives.

3. The Mental healthcare Act, 2017

In The Mental Health Act of 1987 rehabilitation was not focused on. The Act has now been revamped and new act, The Mental Healthcare Act has been brought into being in 2017.

Some salient features of the Act focusing on the issue of mental healthcare provision and abandonment include the following:

- The Act guarantees every person right to access mental healthcare and treatment from mental health services run or funded by the Government.
- It emphasizes on good quality services at affordable cost, in sufficient quantity, geographically accessibility and without discrimination.
- It aims at providing persons with mental illness living below the poverty line or who are destitute or homeless, free of charge service.
- Also, mentions about the provision of halfway homes, shelters accommodations, supported accommodation, group homes which MAY be prescribed.
- The Act aims to provide mental health service in each district run by government with essential drug list free for all with mental illness at government institutes.
- It considers the issue of abandonment and focuses on non-continuation in establishment because of no family.
- Also provision of legal aid and safeguard to the rights of the abandoned has been focused upon.

Policy Gaps

The Act mentions provision of services and rehabilitation to the abandoned mentally ill patients, which in comparison to

the 1987 Act are new, but are the goals achievable as the current health statistics of India tell another story.

- The current scenario of the mental health care in India is astonishing. The median number of psychiatrists in India is three psychiatrists per million people, which is 18 times fewer than the Commonwealth norm of 5.6 psychiatrists per 1,00,000 people (Masoodi A, 2017).
- Similarly, the figures for psychologists, social workers and nurses working for mental health is 0.03, 0.03 and 0.05 per 1,00,000 population compared to a global median of 0.60, 0.40 and 2.00 per 1,00,000 population, respectively. As against an estimated requirement of 11,500 psychiatrists, 17,250 clinical psychologists, 23,000 psychiatric social workers and 3000 psychiatric nurses only approximately 3000 psychiatrists, 500 clinical psychologists, 400 PSWs and 900 psychiatric nurses are available at present.
- The existing training infrastructure in the country produces approximately 320 psychiatrists, 50 clinical psychologists, 25 PSWs and 185 psychiatric nurses per year (Sinha SK and Kaur K, 2011). The all India average deficit of psychiatrists is 77.64% (Roy S and Rasheed N, 2015).
- Only 43 government-run mental hospitals across all of India to provide services to more than 70 million people living with mental disorders. Of the total health budget, a mere 1-2% is spent on mental health (Kulkarni VS, 2017).
- For the existing psychiatrist there is a stigma around being a psychiatrist and they work in private sector in urban area leaving the rural region with 10 million inhabitants with no psychiatric care (Evans J, 2017).
- There is gender-based discrimination in the availability of beds. The male: female ratio for the allotment of beds in government mental hospitals with only service is 73%:27% while those with service, research, and training is 66%:34% (Malhotra S. and Shah R 2015).
- The accessibility of services is questionable looking at the current scenario. The policy mentions about the abandoned people and creation of half way homes and other infrastructural measures but looking at the current government spending on health and mental health, this goal also will take a lot of time before it sees the light of the day.
- There is a need for community-based education to break the stigma and inclusion of day care services which the policy ignores. No importance has been given to family and community psychiatry. Once a person is admitted to mental hospital, he is termed insane or mad by the society. There should be provisions in the act to educate the society against these misconceptions.
- With stress laid on hospital treatment, the home care therapy is ignored and the hospitalization comes with financial burden. The policy also does not make provisions about the financing of mental health services while the economic burden of mental illness contributes significantly to the treatment gap in India (Kaur R and Pathak RK 2017).
- There is no solution to how the system will absorb the growing mentally ill destitute. Firstly, there is a need of mental health care services to reach every district of the country and then supporting institutions for the ill. Further

the gradual resettlement and skill development is needed to give these women a stand in the society.

Gender Analysis of the Policy

Using Naila Kabeer's framework for policy analysis, the Mental Health Care Act, 2017 has many provisions but is Gender Blind. It does not distinguish between different needs of men and women. Does not reach out to the special vulnerable groups like women. It incorporates the existing biases and tends to exclude women. Rehabilitative services talked about but no distinction between the vulnerable populations. No focus on skill development of the cured women and mainstreaming them with provision of opportunities. Institutionalization of women is done to produce evidence against her; the policy does not touch upon such legal aspects. "One size fit all" approach would not be appropriate.

4. Recommendations and Conclusion

With a changing mindset in the world and focus on de-institutionalization with turning of the asylums into hospitals, a long-term stay of patients is not recommended. The society is still not ready to receive the mentally ill back. They will have to face prejudices, treatment gaps and inadequate follow up when not integrated back to society. There are many destitute who are mentally ill women admitted in such hospitals. Even after they are cured, without any fall back option, no bargaining position and severely diminished social capital, they continue their stay in the institutions. They are kept there on humanitarian grounds but on with increasing burden of admissions and seeing the trauma of new patients their condition degrades. There are no opportunities for rehabilitative services, social mobilization and inclusive growth for these women. There is an astounding need for mainstreaming of the women who are cured so that they can create a social position for themselves. The "Band-Aid" approach needs to end and concrete work needs to be taken up for this cause.

A gendered approach to policy formulation

Firstly, an increase in the budgetary allocation to Health and Mental health and focus on formulation of policies that are women friendly is required. The Practical and Strategic needs should be recognized while policy formulation. Recognizing the mentally ill women as a special vulnerable group and realizing their social, cultural, economic, physical constraints and having more inclusive approach for their development could be a step forward.

Culturally sensitive training to the professionals

Cultural, demographic and geographic diversity makes up our country. One size does not fit all. The health care providers should be trained to tackle issues sensitively.

Aggressive media campaigns

A mass change in thinking is imperative to provide respite to women with mental illness. The BCC and IEC Programs should focus on diluting the stigmatization of mental illness and discrimination against those who suffer.

Transitory approach to rehabilitation

De-institutionalization of the patients in a phased manner such that there is a smooth transition of patient from Family to Institute/Hospital to Halfway home and back to Family (Chatterjee R. 2015). Gender sensitivity in institutions is required so that female patients are not neglected and prompt treatment is initiated. A bond between families and patients is maintained and an early intervention is initiated so that illness doesn't worsen to severe psychological symptoms. Half-way Homes should be constructed so that the patients can be shifted there when they are stable. Life skills should be imparted so that they are not alienated in the society. Self-help groups should be formed and the women should be engaged in skill-development activities. Family This is the most important part of the link as the women are not accepted back in society and their own families. Social mobilization and counselling to be carried out and sensitivity developed for the patient. A focused attitudinal change is needed. Also a comprehensive policy formulation focusing on "Rehabilitation and Skill Development" for these women for mainstreaming them in society is needed

Evidence based Research

Feminist Participatory research to be carried out to better understand the women's' perspectives and take evidence based actions accordingly.

Marriage Laws

The Hindu Marriage Act should be amended and mental instability and Unsoundness as a vague term should not be encouraged for a criteria for divorce.

Conclusion

Women with Mental Health issues face discrimination from family and society and additional prejudices. To raise the social position of women, to reorganize the treated women in society, to mainstream them and have an inclusive development for women, it is imperative that we have better decision making, integrated and gender sensitive policies which advocate against stigma and discrimination. Advocacy, a strong political will and community participation is need of the hour to empower the women suffering with mental illness.

5. Appendix

Band-Aid Approach: Not treating the root cause of a problem and trying to find superficial solutions to the eminent visible issues. This does temporary relief but a long-term resolution is not achieved.

Bargaining position: It refers to a how much a person has the power to negotiate or influence the circumstance or decision making with respect to the ability to get what they want.

Care role: the care refers to the unpaid domestic and personal services bound within the ties of kinship and marriage. The women are often defined as the care giver for the family and assigned the role of the care provider under personal ties of loving, doing, loyalty, obligation and trust.

Fall back option: It refers to an alternative plan that is available.

Feminist participatory research: research involving her stories, the women's lives stories, gender sensitive surveys/interviews, autobiographies, case studies. This can be done via purposeful sampling to gather data on a particular issue.

Patriarchal society: it deals with a system of society that is governed by men.

Practical and strategic needs: They are based on Caroline Moser's framework. The practical needs deal with immediate action plan while the Strategic needs define a long term or follow-up plan.

Productive and reproductive roles: They refer here to the roles of the women. The reproductive role of child bearing, feeding, child care, cooking, etc which nurture the family. The productive roles refer to the work other than household work like going to field, ploughing, weeding, planting, earning a wage etc.

Social Capital: It comprises the value of social relationships and networks that complement the economic value. The relations and connections which can add economic value.

Social position: This refers to the position of an individual in the given society and is influenced by social status.

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