CASE REPORT

Social Exclusion and Intolerance towards Persons with Mental Illness: Challenge to Mental Health Care and Social Integration

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ABSTRACT

Background: Social exclusion and intolerance towards people with mental health problems have been seen across the globe and India is not an exception. Their experiences of social exclusion and intolerance include deprivation of chance to participate in social activities and being affected in multiple ways, such as having a low income, poor housing and being socially isolated. Sometimes it also includes severe humiliation and abuse. Ignorance, prejudice and negative public attitudes towards people with mental illness lead to a cycle of distancing and disadvantage which is the biggest challenge to mental health care and social integration of people with mental health problems. **Purpose:** To illustrate social exclusion and intolerance towards people with mental health problems which got comparatively little attention in empirical research particularly in the eastern region of the country. The study also demonstrates the feasibility of social case work intervention in such cases. **Methodology:** The study is based on single subject research design. The case presented here of a middle aged woman who was very much endearing and helpful to everyone around her in the rural community later got a mental illness. Through an in depth case study using face to face interview with her and her family members, a psychosocial formulation was made and a social case work intervention was accomplished associated issues were also discussed. **Results:** Findings of the study illustrate the nature and extent of social exclusion and intolerance of the society towards a person with mental illness which includes sever humiliation and abuse. The role of the family was initially indifferent which was realigned and utilized in intervention which reflected as significant improvement in understanding and awareness about the illness and problem related to that in the family, which ultimately prevented the social execution and enhanced quality of life of the person affected. **Implications:** The study enhanced the understanding on the issue and demonstrated social case work intervention is a good choice for intervening social exclusion. This has an important implication on the lack of awareness about psychosocial intervention and its possible benefit among all the stakeholders of mental health care? This is the biggest challenge to mental health care and social integration of people with mental health problems. **Limitations:** The Single case has its own limitations.

Keywords: Social exclusion, intolerance, mental illness, stigma, discrimination, psychosocial intervention

Access the article online

Website: www.pswjournal.org

Quick Response Code

DOI: 10.29120/IJPSW.2017.v8.i2.33

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How to Cite this article:
Sahu KK, Bhattacharjee K, Sahu S, Mukherjee SB. Social Exclusion and Intolerance towards Persons with Mental Illness: Challenge to Mental Health Care and Social Integration. Indian J Psy Socl Work 2017;8(2): 51-58.

INTRODUCTION

Social Exclusion and Intolerance towards Persons with Mental Illness

Mental illness affects all major aspects of an individual's life. From basic needs such as shelter and employment to interactions with family, partners, friends, and others in the community the diagnosis represent likely difficulties due to stigma and negative attitudes.[1]

Mental disorder is often accompanied by factors increasing the social exclusion and discrimination of persons with mental illness which leads to deprivation of chance to participate in social activities and being affected in multiple ways, such as having a low income, poor housing and being socially isolated. Another problem is deeply rooted stereotypes and prejudices functioning in the public opinion, according to which people who suffer from a mental disorder are considered insane and often dangerous for society.[2] sometimes it leads to severe humiliation and abuse of persons with mental illness.

Public stigma is composed of three types: stereotypes, prejudice, and discrimination.[3] Stereotypes are collective thoughts about a certain group of people that allow one to make a quick assessment or judgment of another person. When one has prejudice, that person believes the negative stereotypes about a certain group. In turn, these beliefs generate negative emotions towards the members of the group.[3] An example of this relates to fear or anger directed towards a person with mental illness due to the belief in the stereotype that all people with mental illness are dangerous. Lastly, discrimination is a behavior directed towards a minority group, such as people with mental illness, that can result in harm, either emotionally, physically, or financially.[3] This kind of discrimination may result in declining people with mental illness from jobs or housing or could result in physical harm to the individual. The other recognized form of stigma, self-stigma, is often internalized and is a result of public stigma. It is stigma directed toward oneself that affects the individuals' self-esteem, motivation, and interactions with other members of society. Stigma is the biggest challenge to mental health care and social integration of people with mental health problems.[1]

Violence

Violence is behaviour that is used to intimidate and assert control over an individual which includes physical, sexual and emotional abuse. The health effects most commonly associated with violence are those that relate to emotional and psychological functioning. The relationship between abuse and mental health is a complex one, and a causal relationship is not immediately clear. Not all people who experience abuse, either in childhood or adulthood, inevitably develop mental illness and not everyone who has been diagnosed with mental illness has experienced abuse. Yet the connection between abuse and mental health is well established. While the immediate health effects of violence are highly visible in the short term fear, bruises, broken bones and death are hard to ignore it can also have profound long term consequences for women's physical and mental health that are not always readily identified or understood. Women who are victims of domestic violence are at a greater risk of mental health problems such as depression and psychotic symptoms in addition to their physical injuries.[4] The different life experiences and roles of a women as wife, mother and primary caregiver combined with social and economic inequality have made women more vulnerable to violence throughout history. Just as women are more likely to experience violence than men, women are more likely to experience a mental disorder.[5] Research has shown that the rate of reported abuse in childhood and/or adulthood among women living with mental illness is alarmingly high: 80% of psychiatric inpatients have been physically or sexually abused.[6]

The onset of mental illness in adulthood can be precipitated by trauma but due to differences in individual backgrounds, symptoms of mental illness can manifest themselves differently in each person and this makes it a challenge to pinpoint the exact nature and course of this relationship. It is suspected that women who are genetically predisposed to mental illness are at higher risk of developing symptoms earlier if they have experienced violence in childhood, and trauma may influence the severity of psychiatric symptoms.[7] When combined with other adverse social and psychological stressors early in life such as poverty and substance abuse, the likelihood of developing mental illness further increases.

Indian Scenario

Stigmatization of people with mental illness has persisted throughout history and it continues to prevail in the present civilized world and India is not an exception. People with mental disorders are, or can be, particularly vulnerable to abuse and violation of their rights.[8] It is a well accepted fact that mental illnesses contribute to significant disability[9] and nearly 13-15 per cent of the India's population suffer from various mental illnesses.[10] Five of the ten leading causes of disability are from the following mental disorders: major depression, alcohol dependence, schizophrenia, bipolar affective disorder and obsessive-compulsive disorder.[11]

Social Case Work is "a process..... to help individuals to cope more effectively with their problems in social functioning".[12] It is a primary method of Social Work which is concerned with the adjustment and development of individual towards more satisfying human relations. It is also one of the direct methods of Social Work which uses the case-by-case approach for dealing with individuals or families as regards their problems of social functioning. Case work aims at individualized services in the field of social work. Casework method based on a systematic and orderly practice which include a process of intake, social study and diagnosis, treatment, termination and follow-up towards problem solution and social functioning among individuals.[13] Various therapies and interventions can be part of social case work based on the needs and suggestibility of the case. There are various approaches and models in social work practice which also implies in a psychiatric setting.[14] In India psychiatric OPDs are generally overburdened with large no of cases and there is very less social work or psychosocial services available and moreover, there is very less awareness about this kind of services and its possible usefulness among professionals. The majority of the persons with mental illness reside in their own house, require help to modify immediate family's attitude followed by friends and neighbours attitudes towards them. This can be addressed through social case work intervention. So this publication may contribute to intervene the situation and also to demonstrate the efficacy of social case work services[13-15] which is very rare in mental health or psychosocial services even though a good number of social workers are practising in this field.[14]

In the present social case work report is depicting a case of a woman who faced abuse and violence from the family members including her partner subsequently got mental illness and continued to face abuse and violence from them and in addition from the fellow community members. Intolerance in terms of abuse and violence towards a person with mental illness and intervention strategies, execution and outcomes were discussed.

METHODOLOGY

A single case design methodology[16] was adopted in order to make an empirical in-depth inquiry about a contemporary phenomenon of Social exclusion and intolerance towards people with mental health problems. Case study research is a good fit with many forms of social work practice[17] used widely by Psychiatric Social Workers [14,15, 18-20] and other mental health professionals as well.[21-23] The case study has great potential for building social work knowledge for assessment, intervention, and outcome.[17] Through an in depth case study using face to face interview with her and her family members, a psychosocial formulation was made and a social case work intervention was accomplished associated issues were also discussed.

ASSESSMENT

Case Introduction: Index client Mrs. K.K. 44 years old Bengali married, female, hailing from a lower socio-economic class nuclear Hindu family from a rural area of West Bengal, India. She was a home maker and studied up to class VIII.

Sources of Information: The client herself, her husband, client's son, client's sister-in-law and case record file were sources of information which were reliable and adequate.

The reason for Referral: The case was referred to the Department of Psychiatric Social Work of a tertiary care teaching institution for psychosocial assessment and intervention on 27th September 2013.

BRIEF CLINICAL HISTORY

Chief Complaints:

- Aggressive behaviour
- Having tension

} since last 7 years

- Impulsive thoughts
- Irresistible desires

} since last 5 years

- Assaulted by neighbours & family member
- Being socially isolated

} since last 4 years

with insidious onset, continuous course and Improving Progress

- **Predisposing factor:** Client's personality factor and the change of family environment, lack of emotional support and increased in responsibilities after the marriage of the client.
- **Precipitating factor:** Break down of social support systems.
- **Perpetuating factor:** Physical and mental assault by the family members and neighbours along with the lack of awareness about the client' illness.

The first contact with the institute was 2012 where she was diagnosed as OCD. She has been suffering from last 5 years, treated with Selective serotonin reuptake inhibitors (SSRIs) and shown improvement to some extent but stopped medication due to delayed consultation and her symptoms get worse again. Later her diagnosis was revised as OCD with psychosis and treated accordingly. At the time of referral, she was not on regular medication. She has partial insight (grad III). Her biological factions were reported to be normal except disturbed sleep. There was marked deterioration in socio-occupational functioning of the client.

LIFE COURSE AND DEVELOPMENT OF MENTAL ILLNESS

The Client was having nil contributory personal and past history and well adjusted premorbid personality. The Client was outgoing, social, friendly by nature he had good relation with siblings and peer. In extracurricular activity the client learned classical singing. She enjoyed to be follower and was socially popular. The client used to participate in group activities. The client started going to school at the age of three and half years, which was very near to his house. Her educational performance was also satisfactory. A good relationship was maintained with the teachers. The client loved to do maths.

When Mrs. K.K. completed class VIII, the parent got her married that time she was just fifteen years old. After marriage she started leaving in a joint family[24-26] with her husband, his (husband's) parents and his three brother-in-laws, their wives and children. Somehow, she was happy even though she had to do lots of house hold work because she was youngest among the others.[25, 27] Her husband was much (around 19 years) elder than her and at that time her husband's income was not good and being younger, in all matters her husband had to be dependent on his elder brother's decisions; (she reported) by nature he can be easily influenced by other family members even with neighbours. So, many times she did not find adequate support from her husband which she felt tough but tolerated calmly. Initially, she was liked by others since she was very much chatty, outgoing and very much helpful to everyone around her not only inside the family but in her whole community.

Within one year she got a baby boy. She reported others were neither helping much in child care nor there was any relaxation in routine house hold work, instead of that she was blamed for not taking proper care of her child. According to the client now, the family members did not appreciate her helping nature and accused her of giving lots of things from their house to the needy people who came to her for help. According to client's husband the client used to give vegetables, cereals etc. from the grocery store and because of her helping nature many people used to take advantage of her. She was not able to change her helping nature which she developed in her adolescent age before getting married. According to client's sister in law, whenever anyone tried to restrict her for the helping others she used to oppose aggressively and some time it turned to quarrelsome.

Four years later she gave birth to a baby girl. She felt tough to take care of her two children along with her daily house hold work but like earlier she was blamed for not taking care of her children which her husband also agreed. She reported due to house hold work some time she had to leave her children alone though there were so many other people around. At times the baby started crying since she postponed to feed her or to change her wet nappy pad but instead of helping her she

was scolded and blamed. In such situations there were occasions when she got irritated and also lost her temper which turned into quarrel but again the whole thing came to her head only. She was accused as a very aggressive and quarrelling person who quarrelled with everyone for little issues and after quarrelling, to express her anger she used to through utensils, serial etc. or given house hold materials to others without any need or to throw all the materials on the road or throw cereals in the pond when she was alone in the house. She felt extremely disappointed but no one even husband was supporting her so she kept mum. In a way, she becomes quite alone in the family but somehow manage to 24 long years in the quarrelsome situation.

As time passed and children were grown up she got some support from her children. Under their (children) pressure her husband decided to get a separate house from the joint family but unfortunately after being separated, she had to encounter another set of problems with was more distressing than earlier one. All the day she had to stay alone in that house. She was feeling lonely because she enjoyed to mix up with peoples & loved to maintain relationships with other family members. One year later her daughter got married. Now she became very alone because her husband was a farmer, he usually kept busy with his farming work whole day, her son was also busy with his work, only her daughter used to spend a lot of time with her and understood her feelings. The client was also good in maintaining relationships with neighbours. So, after her daughter's marriage she used to spend lots of time with them but situation became worse when she got hurt by hearing that some people who used to take help from her, making laugh of her by gossiping about her helping nature and also misusing her by taking help time to time. So, she isolated herself from all the neighbours and now again became lonely.

According to the client at that time she had impulsive thoughts - something like throwing all serials in the pond and an irresistible sudden desire to plucking up the crop plants or fruits from the fields. This desire became so intense that she was unable to control herself. So, a couple of times she plucked neighbours plants, fruits, flower and branches or broke dry cow dunk from the wall etc. Her reputation became very worst in her village. For that reason, husband used to verbally assault her and had to lock her in a room whenever he was not present and also physically assaulted her very badly. No one has any idea what is happening to her so, not only her family members but also neighbours got annoyed with her. In previous days whom she helped in their difficult time, they also became against her. Her husband and all the neighbours thought that her activities were just to make irritate them and together they assaulted the client in many times very rudely.

One year later she was taken for treatment and there was slight improvement on her behaviour but stopped medication because of delayed consultation but client's husband reported that treatment for the client shown no improvement rather when she got any chance to go outside, she plucked neighbours plants, flower, branches or broke dry cow dunk cake from the wall etc. So, she was referred for psychosocial intervention along with medications. Even though, after initial assessment compliance counselling and psychoeducation was done, compliance remained poor and her symptoms get worse again. So, this time during the course of treatment once she was beaten up so badly that her both legs got fractured.

Life Chart of the Client

Year	Client's Age	Events
2013	44	Referred for PSW intervention
2012	43	First contact to IOP
2011 2010		No Treatment
2009	40	Daughter's marriage (21 yrs.) & ↑ Illness
2008	39	Separated from the joint family
2007	38	0nset of illness
1988	19	Daughter's birth
1985	16	Son's birth
1984	15	Completed class VIII & Married

FAMILY HISTORY

Family history of medical illness: In paternal side, her father died in suffering from cancer. In client's maternal side mother died in stroke. Client's elder most brothers have a history of stroke attack & client's elder sister has asthma. Client's younger most sisters have some physical illness (details not known). In client's maternal side her youngest sister who is just after the client committed suicide due to depression (Figure 1).

Family Composition

Previously client and her family lived in a joint family with other in-laws but they started living separately.

- **Husband:** Client's husband is 58 years old male educated up to Class eight and working as a farmer. He often assaulted client for her illness and can be easily influenced by neighbours or other family members.
- **Son:** Client's son is 28 years old male, educated up to higher secondary and working in a private company. He is very much concerned and supportive towards her mother's illness.

Figure 1 Genogram: Family of Origin

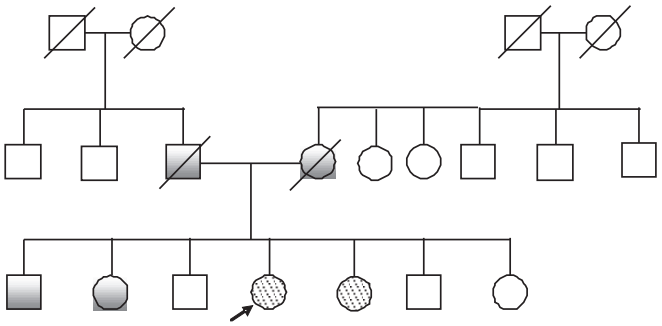
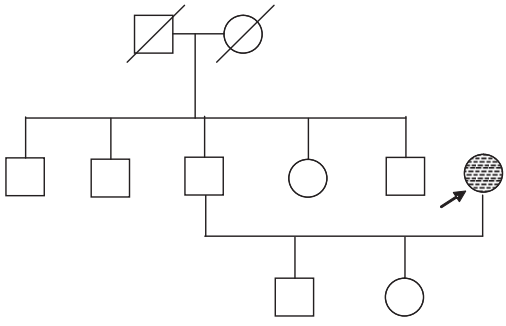


Figure 2 Genogram: Family of procreation



- **Daughter:** Client's daughter is 24 years old female, educated up to B.A. married and working as home maker. She can understand client's illness & give support and care to her mother.

General patterns of living

Presently the client lives with her husband and son in rented house of a four storied building which monthly fare is three thousands. The client lives on the top floor. The environment of that is not good at all. In the client's portion, there are two small dumpy rooms. One kitchen, one bathroom. The rooms are not speacious. Water facility is available in his house. No other modern facilities are available except gas oven, and for recreation, a colour TV is also there.

INTERVENTIONS

Goal of Interventions: Based on the assessment findings to address psychosocial problems the following goals were set:

- To build rapport with client
- To facilitate client's insight into her problem
- To enhance treatment compliance
- To educate family regarding the illness of the client
- To minimise the expressed emotion towards client
- To ensure no more physical assault on the client.
- To utilise support available for the family

Interventions

All intervention was done as OPD basis, initially planned biweekly session lasting around 45-60 minute then monthly and subsequently once in three months but due to non compliance it was not held as per the planned. The majority of the sessions were individual with the client and her husband separately and jointly, but 2 sessions with her son and one session with community members were held which includes:

- ✓ Psychoeducation
- ✓ Family intervention
- ✓ Community sensitization
- ✓ Follow up
- ✓ **Building rapport with the client:** Initially the client wasn't ready to talk but he was responding with yes

or no in the first session. Subsequently the rapport was stabilised by active listening and reassuring and other supportive measures.

- ✓ **Psychoeducation:** After rapport was establishment the client becomes co-operative and ready to receive treatment. So, case worker started with a psychoeducation to the client and her husband about the illness (nature, causes, course, treatment, and prognosis), need and importance of the treatment. The client's behaviours and possible reasons were explained to her husband with emphasis that it is an illness which can be treated. Subsequently he realized that he could have been supportive instead of assaultive towards her, he regretted that he could not supported her in tough time and also acknowledged her sincere work and care towards all. Later her son has also imparted the knowledge about her illness. Sessions were with examples and illustrations and also exposed to a group session where clients and caregivers of OCD were participating. The phenomenon of obsession and compulsions were demonstrated by others so that they could understand various type of the obsessive thoughts and compulsive acts.
- ✓ **Family intervention:** Further family sessions were focused on minimizing the expressed emotion towards client and ensuring no more physical assault on the client. They were trained to keep consistent communication with the client and to engage her in house hold activities like earlier she used to do. They were made realized that the need to continue medication and support will keep her symptoms under control which was seen in earlier treatment. To reassure them contact numbers were given and suggested to contact in the crisis situations.
- ✓ **Community sensitization:** A group of professional trainees visited the home of the client and neighbourhood and educated them about her illness and emphasised the need for their support. Her good work and relationship were reminded and appeal to support her instead of assault which can give her strength for recovery.
- ✓ **Follow up:** The client and family were kept on consistent active follow up through phone to maintain therapeutic relationship.

OUTCOME

In due course all problems targeted under the goals were minimized or improved significantly.

DISCUSSION

The present case report depicted how a socially well adjusted women was socially exclude and profound intolerance towards her was shown by his own family and community members which shaped a challenge to her mental health and social integration.

In this case, violence or assault played significant role in, predisposing, precipitating, and perpetuating the client's illness which is not a new story in a of woman with mentally ill.[6-8] Being a "woman" and being "mentally ill" is a dual curse. Mental health services are sought infrequently and late. Rather she is blamed for the illness. The mentally ill woman may be socially ostracized and abandoned by her husband and her own family.[28]

This case report is following a life course approach to mental health which is based on the understanding that multiple factors, including biological, social, psychological, geographic, and economic, shape mental health over the life course through risk mechanisms that are independent and cumulative and interact over time.[29]

CONCLUSION

This case report based on a life course approach to mental health explicitly recognizes the importance of time and timing in understanding causal links between exposures to psychosocial factors and outcomes within an individual life course. It also depicted feasibility of social case work interventions with such cases and possible positive outcomes.

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