The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 11, Issue 2, April- June, 2023
DIP: 18.01.018.20231102, DOI: 10.25215/1102.018
https://www.ijip.in

Case Study

Stigmas Against Mental Health in India: A Case Study of Hanumangarh, Rajasthan

Vishakha Choudhary[1]*

ABSTRACT

Objective: Today, the popular culture in the West has normalized the importance of mental health and the treatment of mental health issues. With ever-increasing access to technology and technological advancement, information about mental health and mental health issues is ideally available to everyone. This paper tries to test the perception of people towards mental health issues in India by using a semi-urban Indian town as a case study. **Methods/Design:** The paper uses already existing literature as its base methodology and interviews of mental health professionals in Hanumangarh, Rajasthan. The questions are about the professional's everyday experiences working in a semi-urban setting, the number and types of clients they see, the clients' and the general public's opinion on mental health, and the professional's opinion on things that could be done to reduce stigma against mental health issues. **Results:** Already existing literature shows that in India, mental health issues are stigmatized and this stigma can have serious impacts like delay in treatment. The availability of information has also had its repercussions like the inappropriate use of mental health-related vocabulary which further puts shame on people going through mental health issues. The answers from the professionals also corroborate this narrative. **Conclusion:** India has come a long way in its perception of mental health and mental health issues. However, a lot needs to be done to destigmatize mental health entirely. People are more open to psychiatric intervention but don't have the same amount of faith in non-medicinal therapy approaches.

Keywords: *Stigmas, stigmas against mental health, mental health in India, treatment of mental health issues in India*

Mental health is referred to as "a person's condition concerning their psychological and emotional well-being". Similar to other areas of well-being, mental health issues have their impacts on society. "In India, WHO estimates that the burden of mental health problems is of the tune of 2,443 DALYs per 100,000 population, and the age-adjusted suicide rate per 100,000 population is 21.1. In India, it is estimated that the economic loss, due to mental health conditions, between 2012-2030, would be 1.03 trillion of 2010 dollars" (World Health Organization, 2019).

[1]Master's Student
*Corresponding Author

Received: January 23, 2023; Revision Received: April 18, 2023; Accepted: April 22, 2023

With that being the case, India has less than one mental health professional for 100,000 people. This is a trend regardless of the professional (nurses, psychiatrists, psychologists, social workers). This data shows that while there is a huge problem, there is a lack of personnel working toward the solution/adequately addressing the problem. A primary possible reason behind this could be the association of stigmas with the situation. India introduced its Mental Health Act in 2017 and enforced the same in 2018. Suicide (which in many cases is related to the problem of mental health) in India is seen as a crime, not a cry for help or a sign of mental health illness.

For a generation of people raised before the Mental Health Act, conversations about mental health and well-being were minimum. In some cases, like mine, mental health awareness or education was not given priority in upbringing. Not being aware of mental health and issues around mental health until the age of 16 made me curious about people's perceptions of the same and has motivated me to study psychology and pursue this topic. This lack of proper conversations about mental health for the majority of my life is why the study will look at stigmas against mental health in my hometown (Hanumangarh).

To ensure a better future, one has to look at the problems in the present. Unfortunately, conversations around mental health are filled with stigmas. To ensure that the future does not have the same issue, one must first understand stigmas against mental health to eradicate it (stigmas). Some questions that it (the paper) aims to answer are:

1. In what ways do different people (patients vs professionals) face stigmas?
2. The type of obstacles people who go through mental health issues face in receiving proper treatment.
3. Is there an increase in community awareness of mental health and mental health issues?

METHODOLOGY

"Hanumangarh is a district in Rajasthan near the Punjab-Rajasthan and Haryana- Rajasthan border making it a mix of languages and cultures. Hanumangarh has seven tehsils and 1831 villages (the total number of villages is 1907, but 76 are uninhabited. Hence, we will not look at those). The population is 80.3% rural and 19.7% urban, with a 67.1% literacy rate" (Census India, 2011). The paper tries to look at stigmas against mental health from the perspective of mental health professionals.

The study uses already existing literature on mental health and stigmas against mental health as its base methodology. Looking at existing literature on relevant topics has helped show the applicability of other forms of scientific inquiry and multiple perspectives on stigmas against mental health.

The other form of scientific inquiry that the paper uses is semi-structured interviews. One of the best ways to understand the existence of stigmas against mental health is by looking at it from the perception of people who go through it. These people would involve patients (who go through mental health issues), caregivers, and mental health professionals. People going through severe mental health issues can have problems with consent and perception of reality, making them ineligible to participate.

A caregiver would only know about the patient they are looking after and would have bias, making them unable to give an objective, holistic picture. Because of these reasons, the paper relies on interviewing mental health professionals, for they would have the clarity that

the patients lack and would be able to convey more in breadth and depth about the actual scenario (unlike the caregivers).

The interviewees for this paper include psychiatrists and a psychologist. The mental health professionals see patients from the town (Hanumangarh) and help patients from nearby rural areas. Hanumangarh has four mental health centers. Out of four, professionals from two centers consented to interviews. The analysis of this paper stems from conversations with three professionals.

LITERATURE REVIEW

Before diving into the arguments that existing works of literature make, one has to look at how mental health is prioritized in India. While looking at the health budget, it is evident that mental health does not get the same priority as other health-related programs and policies. The significant evidence supporting this idea is that India spends less than 1% of the health budget on mental health (before Covid-19).

One concept that sticks out in the current works is that the general public is unable to readily identify mental health issues. This, when studied, was found to be due to a lack of vocabulary (Chowdhury, 2019). Terms like schizophrenia are not used by the general public and are never taught in any curriculum. There are some exceptions to this as well. However, just because the general public is using a term does not equate to an understanding of the concept.

For example, depression (as a disorder) is often used to depict sadness due to an unfortunate event, and anxiety is used to show nervousness.
Like everything that exists, stigmas against mental health also have their consequences.

One severe result is that people refuse to acknowledge mental health or its importance. This leads to people not receiving adequate treatment. While most literature supports this, a particular study depicts a different painting of a picture altogether. This specific study discusses how blaming an unchangeable external factor for a mental health issue can make a person receive treatment more quickly.

However, more often than not, the blame is put on the patient. Making the study by Jain & Gautam (2012) an exception (not the norm). The standard, however, is that people with mental health issues face stigma from the outside world and feel ashamed about having the illness (Boge, 2018). These combined make the person neither talk about the problems with anyone nor seek treatment (with delayed treatment being the best case in these situations).
Moreover, in countries like India, religion plays a significant role, further contributing to the delay in treating a person with mental health issues. Absolute reliance on religion, along with a lack of mental health literacy, results in people going for informal sources of 'treatment' rather than seeking help from a mental health professional (Gautam, S., Jain, N., Gupta, I. D., & Singh, H, 2012). Though this is the case, not much has been done about understanding how to improve the situation. This is a significant gap in the existing literature.

Some surveys have found a significant gap between literacy and mental health literacy in India. However, there is a lack of discussion about the potential approaches to bridging the gap.

In their attempt to answer specific questions, the existing literature brings up more questions. For starters, is the use of mental health-related terms accurate? Are mental health-related words used because people know the issues and have a new vocabulary to express them? This adds new perspectives to the community awareness aspect of the research questions. A lack of knowledge about a topic results in assumptions: more often than not, assumptions do harm rather than help. If the lack of knowledge persists, assumptions can very well turn into stigmas.

As mentioned above, the mental health budget (of India) and the number of professionals per 100,000 people are meager. Yet, the existing works have not looked at the stigmas faced by mental health professionals. This inspired the study to look at the stigmas that professionals face from a holistic perspective (involving stigmas they see during their work hours and outside).

There are also conflicting views on the role that religious beliefs play in a patient's treatment (or lack thereof). As discussed above, while the role of a particular faith may be positive, it is limited to that specific belief. India is full of different religions. Some religious practices may even create stigmas and further cause problems.

For instance, if a person talks about their trauma and its impact on their daily functioning, and if the listener (family member in this case) prioritizes religion-oriented practices (over actual mental health treatment) may force the person to do some unrelated ritual that might scar the person for life. The person in this instance may never open up again about their trauma and continue to live their lives facing the consequence of not only the trauma but also the 'treatment'. This brings in the questions, "do all religious beliefs bring the patient one step closer to receiving appropriate treatment?"; "Are religious beliefs hampering in the majority of the cases, or can they result in something positive?" and "do religious beliefs play a role in stigmatizing mental health issues?".

Lastly, the lack of existing works' attempts at looking at the type of education to eradicate mental health illiteracy brings in the question, "what type of mental health literacy would bring about potential change?". It also brings about the question, "if India can adopt mental health education programs from other countries". This, combined with a significant gap in literacy and mental health literacy, brings in the factor of involving mental health education as a part of the basic curriculum. How can the education system account for the majority of the population (involving those who quit education early)? At what stage of the basic curriculum should mental health education be involved? Questions like these have stayed unanswered for a while and should be addressed.

Interviews

As mentioned previously, professionals from 2 out of 4 centers agreed to be interviewed. These involve two psychiatrists (who would be referred to as VJ and OS) and one psychologist (who would be referred to as DJ). Dr. VJ and DJ work together in the same clinic, and Dr. OS runs a separate clinic. These professionals see at least 300 patients from Hanumangarh and nearby rural areas per day.

One professional from the third center denied consent to be interviewed. No mental health professionals were available at the fourth center as they were on leave and there was no other staff available.

The information sought related to the following categories (the questions can be found in the 'annexure' section):

- about the professionals
- patient-related data
- questions that directly address stigmas about/around mental health issues and treatment
- open-ended questions on the interviewee's thoughts on the current situation and scope for improvement.

Dr. VJ started his career as a psychiatrist in 2007. At the start of his career, he noticed that people preferred religious 'treatments' over standard treatments and had most of his patients referred to him by a General Practitioner (GP). However, he reports that currently, there is little to no stigma when it comes to reaching out to a mental health professional. On the contrary, that word of mouth communication has increased community awareness of psychosis and the need to seek proper treatment. The only misconception regarding treatment (according to him) is that the general population considers psychiatric medication to be addictive.

The next interviewee, DJ, started her career as a clinical psychologist in 2009. She says that people do not believe in the therapeutic measures that she provides. She reports a lack of job satisfaction and attributes the increase in the number of patients she sees to her husband's (VJ) referral and not to an increase in understanding of her work. She talks about how people do not believe in self-care and even regulating their medication (some even use the same prescription for a decade). She emphasizes the importance of basic literacy to make therapy more approachable to the general public (therapists require the patients to fill out questionnaires before starting the treatment).

Dr. OS graduated with an MD in psychiatry and started his career as a psychiatrist in 2016, before which he was a general practitioner in a rural area. He reports that people still consider psychiatrists and other mental health professionals as doctors for "mad" people regardless of education. He talks about how people misuse mental health-related terms (for instance, referring depression to as mania). He reports an increase in the number of patients he sees per day (from 15 to 150) and mentions referrals from GP and "religious doctors" (aka babas and tantriks). He connects the earlier mentioned misconception about doctors for "mad" people by talking about how patients only show up when things get way out of hand, expecting a short treatment (as the medications are addictive).

Interestingly, he mentions how people in the urban areas of Hanumangarh & Bikaner (both in Rajasthan) have people who want to conceal that they seek treatment for mental health issues. He also mentions that, unlike people in nearby villages, people from urban areas do not wish to be seen entering the clinic and try to show up at odd times (hinting at feeling shame). He attributes mental health issues in youth to technology and advises that people not use technology for better mental health. However, he contradicts himself by suggesting mass media as a way of raising mental health awareness.

These accounts vary significantly in detail. Starting by looking at the professionals themselves, Dr. DJ is one of the most established (if not established) mental health professionals in the area. This could be one of the reasons why he reports no stigma. Another potential attribution for the same could be that he started more than a decade ago (a

lot of changes can happen in a decade), which could mean that the struggles he saw at the start of his career make the current battles against stigmas appear insignificant.

More interesting to note here is that, though DJ started her career way before Dr. OS, Dr. OS reports better job satisfaction. This can easily be attributed to the general public's faith in traditional medicine over therapeutic measures. While all of them mentioned an increase in the number of patients they see, it was due to word of mouth for the psychiatrists, but for the psychologist, it was only due to referrals.

While both the psychiatrists pointed out that people rely higher on "religious treatments" and seek the same before showing up (to seek treatment from the psychiatrists), it was not even a concern for the psychologist (which can be understood as all of her patients are referred by a psychiatrist). Both psychiatrists talk about the influence of attendants on people going through psychosis.

However, Dr. VJ's accounts hint at stronger relationships leading to a more quick recovery, and Dr. OS's accounts hint at stigmatization (from the attendant for the person going through mental health issues). Unlike Dr. VJ, the lesser established counterparts reported increasing education to make people more open to therapy. While DJ talks about general literacy and education, Dr. OS discusses mental health literacy.

Dr. OS was also more open about the topic of the interview. This can be attributed to him being relatively new to the field compared with VJ and noticing more consistent changes in the way he sees his patients (compared to DJ). However, all three mental health professionals agreed that there is a high reliance on medication than on other therapeutic approaches. They also shared a common opinion that people are not likely to indulge in self-care and maintenance (regardless of whether it comes from a psychiatrist or a psychologist).

These interviews also bring up the following questions:

- Can higher experience in a field make a person's accounts less reliable? If so, then at what stage do researchers draw the line?: As seen above, the main difference between the accounts given by Dr. VJ and Dr. OS (though both of them are psychiatrists and have equal respect among the general population) is that Dr. VJ started his career before Dr. OS and Dr. VJ reported an absence of stigma, unlike his counterpart.
- Are the existing therapeutic methods (adopted from the west) reliable in India? How much modification is required? Does India need new personalized versions of already existing therapies? What would these versions look like?: As seen from the account given by DJ, people in semi-urban areas can not even fill out the questionnaires required before starting therapy. This could also mean a lack of ability to understand the basic concepts required to effectively go through the westernized therapeutic methods.
- What type of education would lead to an increase in accepting mental health issues? Is it basic literacy or mental health-specific literacy?: As seen in the accounts given by DJ and Dr. OS, there are two major concerns around literacy. First, the major concern is around understanding (from the general public) the basic requirements of therapeutic methods. Yet Dr. OS’s account reflected that educated people were also not open about mental health issues. This raises concerns about the type of education to be implemented.

OBSERVATIONS AND CONCLUSIONS

The primary commonality in the existing literature and the accounts provided by mental health professionals is that religious beliefs can act as a barrier to providing mental health care. Therefore, the reports from the professionals reflect the importance of having faith.

Unfortunately, people have more confidence in religion than a professional dedicating their lives to treating mental health disorders. When combined with prejudice, this absence of trust results in patients receiving the treatment a little too late. And it is at that point, the already existing stigmas against mental health align with a patient's condition.

For example, there is a stigma against people going through mental health disorders that they are "mad" or that they are not capable of understanding the world around them. This stigma becomes a reality when the patient is denied treatment for too long and gets into a stage of psychosis. A situation like this could potentially make the stigma stronger. In such cases, mental health professionals have no other choice but to go into damage repair mode, making the actual treatment far too long. Had there been less absolute faith in religion, a circumstance such as this could easily be avoided.

One primary argument in the existing literature is that having a better socio-economic status makes one less likely to have stigmas against mental health. The reports from interviews, however, reflect a different story. Accounts from interviews show that stigmas have different ways of representing themselves. For the better socio-economic class, it is far more subtle. For example, stigmas against mental health and treatment of mental health disorders are often seen as scheduling appointments exceptionally early or late in the day.

This is usually done to ensure that nobody notices the person entering or leaving a psychiatric facility. This disparity between arguments from the literature and the interviews can easily be attributed to the fact that the results rely on self-reports by the general public whereas, the discussions rely on reports from professionals. This disparity also highlights the differences between how people want to be perceived and reality.

While people from better socio-economic status are aware of mental health, it is usually assumed that "others" (of the same class or not) would judge them. This explanation justifies the disparity and helps in looking at the knowledge vs applicability of things. It is not necessary that every person who is aware of mental health may look at it positively.

While scholars are looking for technology-based solutions to make mental health more accessible, professionals argue that technology isolates people, making them more vulnerable to mental health issues. Both these statements hold some value. The existence of technology has made life more tricky. Social media websites are designed to provide one with more of what they seek. For instance, if a person searches for a flashlight online, they will receive ads for flashlights on their social media. Constant consumption of social media also makes people compare themselves to influencers and project their lives as perfect. All of this can cause strain on individuals and make them more vulnerable to disorders such as anxiety and depression.

Therapy relies heavily on confidentiality because of which leaving a footprint online can do more harm than good. An example of this is "BetterHelp", which is an online therapy service. People who used this service reported extremely unprofessional behavior from their designated mental health professional. Some even said that the person on the other end didn't

act like a mental health professional (reacted more like an individual without proper training).

However, technology is not all bad. For example, there are services like "7 cups" that provide you with trained listeners. Any individual can be a listener as long as they go through and pass an online training program. In addition to enforcing stronger community relationships, such services provide SOS solutions for people going through mental health issues. These services also help in destigmatizing mental health issues and removing the shame around them.

Hence, the role of technology is highly debatable and a topic that is subject to personal use. In conclusion, stigmas against mental health are still prevalent. While there is some progress, an optimum state is still a long way to go. Moreover, due to the vast diversity in socioeconomic status, stigmas against mental health have become a more complex issue and need to be tackled from a different approach. This approach can not be the same for everyone and will be subjected to modifications based on the population receiving it. It was also observed that there could be a need for new therapeutic methods and mental health literacy reforms. While the gap between literacy and mental health literacy is significant, a plan for India will have to account for illiterate people too. Otherwise, a massive chunk of the population would be excluded (as seen in DJ's accounts).

Limitations and Scope for Further Research

As seen, the paper talks about stigmas against mental health by taking a small town in Rajasthan as its case study and represents the situation from the perspective of mental health professionals working in the area. The aim (as discussed previously) was to ensure that the paper covers as many aspects of stigmas as possible and does so in the most objective way possible.

The paper represents the population of Hanumangarh, which is a mix of ethnicities and beliefs as Hanumangarh connects three states (Rajasthan, Haryana, and Punjab). However, studying a phenomenon in India is complicated because of the diversity in almost all aspects of life. India is a highly diverse country, due to which anyone who wishes to study a phenomenon would find different results based on the geographic location. Therefore, while this paper can potentially serve as a base for other articles, unfortunately, it cannot represent the entire country.

Another limitation of the paper is that it does not take the general population's accounts into the picture. Hence, one of the scopes for further research on the topic could be a comparative analysis of reports from the general public vs the people who face stigmas against mental health. All these aspects make the further scope of research on the topic endless.

REFERENCES

Budget 2019: Rs 62,398 CR outlay for health sector; rs 6,400 CR earmarked for Ab-PMJAY. The Economic Times. (2019, July 5). Retrieved December 4, 2021, from https://economictimes.indiatimes.com/news/economy/policy/budget-2019-rs-62398-cr-outlay-for-health-sector-rs-6400-cr-earmarked-for-ab-pmjay/articleshow/70092337.cms

Hanumangarh tehsil population, religion, caste Hanumangarh District, Rajasthan - Census India. www.censusindia.co.in. (2011). Retrieved December 4, 2021, from https://www.censusindia.co.in/subdistrict/hanumangarh-tehsil-rajasthan-468

Mahajan, P. B., Rajendra, P. K., Sunderamurthy, B., Keshavan, S., & Bazroy, J. (2019, June 19). *Analyzing indian mental health systems: Reflecting, learning, and ...* Journal of Current Research in Scientific Medicine. Retrieved December 4, 2021, from https://www.jcrsmed.org/article.asp?issn=2455-3069;year=2019;volume=5;issue=1;spage=4;epage=12;aulast=Mahajan

Chowdhary, A., Gupta, K., & Patel, A. K. (2019). *Attitude, belief, and perception toward mental illness among Indian ...* MAMC Journal of Medical Sciences. Retrieved December 4, 2021, from https://www.mamcjms.in/article.asp?issn=2394-7438;year=2019;volume=5;issue=2;spag e=83;epage=88;aulast=Chowdhury

Böge, K., Zieger, A., Mungee, A., Tandon, A., Fuchs, L. M., Schomerus, G., Tam Ta, T. M., Dettling, M., Bajbouj, M., Angermeyer, M., & Hahn, E. (2018). *Perceived stigmatization and discrimination of people with mental illness: A survey-based study of the general population in five metropolitan cities in India*. Indian journal of psychiatry. Retrieved December 4, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5914258/

Jain, N., Singh, H., Koolwal, G. D., Kumar, S., & Gupta, A. (2015, February 4). *Opportunities and barriers in service delivery through mobile phones (mHealth) for severe mental illnesses in Rajasthan, India: A multi-site study*. Asian Journal of Psychiatry. Retrieved December 4, 2021, from https://www.sciencedirect.com/science/article/abs/pii/S187620181500009X

Gautam, S., Gupta, I. D., Jain, N., & Singh, H. (n.d.). *Development of Jaipur Stigma Questionnaire: A ...* Original Article. Retrieved December 4, 2021, from http://ipsnz.org/wp-content/uploads/2019/10/6_OriginalArticle4.pdf

Jain, N., Gautam, S., Jain, S., Gupta, I. D., Batra, L., Sharma, R., & Singh, H. (2012, July 11). *Pathway to psychiatric care in a tertiary mental health facility in Jaipur, India*. Asian Journal of Psychiatry. Retrieved December 4, 2021, from https://www.sciencedirect.com/science/article/abs/pii/S1876201812000755

Jain, N., & Gautam, S. (2011, July 26). *'mental illnesses are a result of deeds of past/present life': Looking at the other side of the coin*. Taylor & Francis. Retrieved December 4, 2021, from https://www.tandfonline.com/doi/abs/10.1080/17542863.2010.541067

World Health Organization. (2019, May 17). *Mental health*. World Health Organization. Retrieved December 4, 2021, from https://www.who.int/india/health-topics/mental-health

Acknowledgement

The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest

The author(s) declared no conflict of interest.

How to cite this article: Choudhary, V. (2023). Stigmas Against Mental Health in India: A Case Study of Hanumangarh, Rajasthan. *International Journal of Indian Psychology, 11(2),* 205-213. DIP:18.01.018.20231102, DOI:10.25215/1102.018