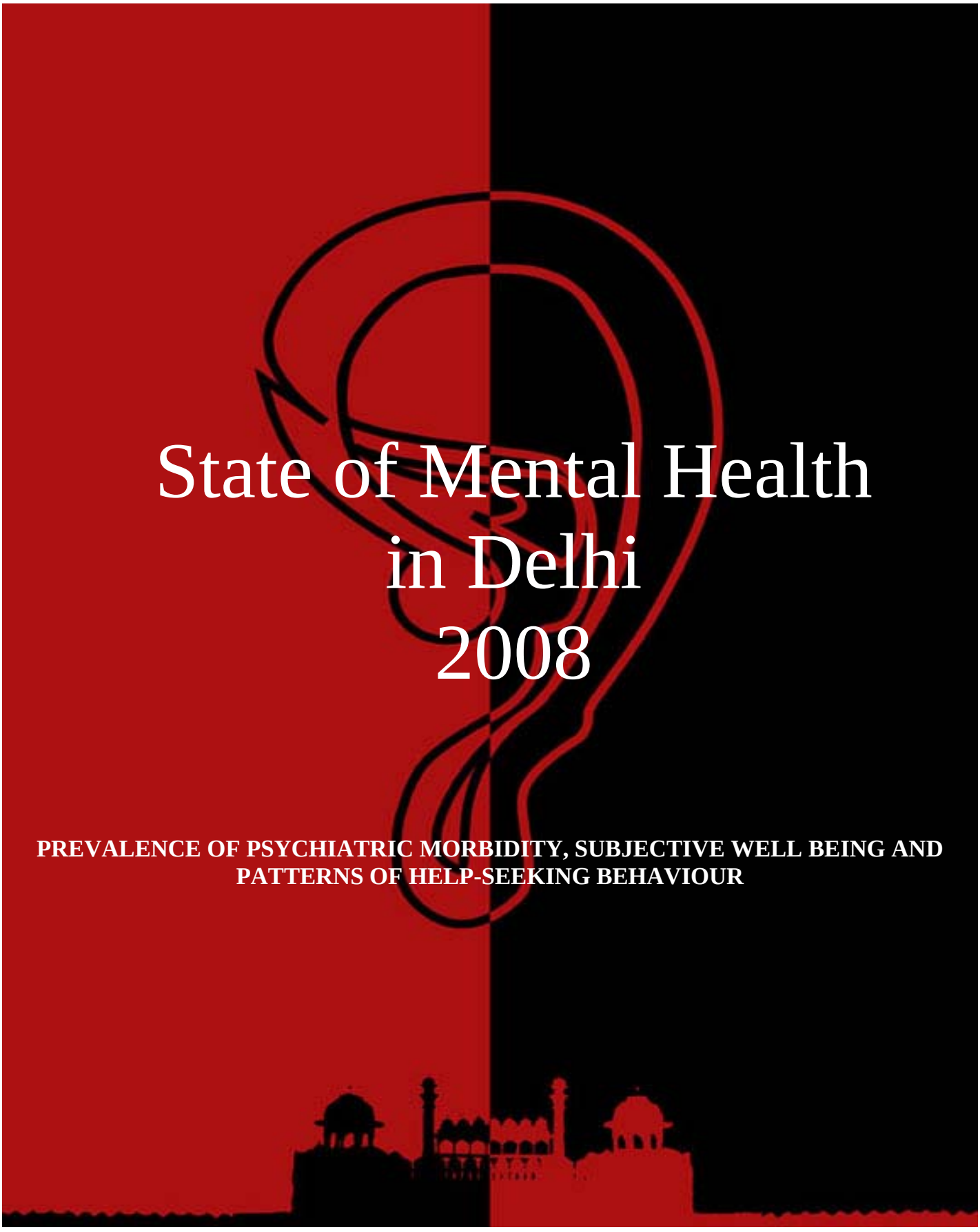

State of Mental Health in Delhi 2008

PREVALENCE OF PSYCHIATRIC MORBIDITY, SUBJECTIVE WELL BEING AND PATTERNS OF HELP-SEEKING BEHAVIOUR

Acknowledgement

We are grateful to the Planning Commission for entrusting us with the responsibility of conducting this study. We thank the Socio Economic Research (SER) Division for supporting us to undertake the study. We are specifically thankful to Mr. B. S. Rathor, Sr. Research Officer, who guided us in the statistical design and questionnaires of the study. We hope that the confidence reposed in our abilities has been justified.

Conducting this study has been a humbling experience. We thank the collaborating RWA's, leaders and influential persons of civil society, and the many participants who gave their time to help us understand their problems and needs. We at Manas have learnt much from them. It has enriched us both professionally and personally.

Dr. Devendra Singh Digari and his team undertook the data collection, data entry and analysis with commitment. Dr. Naved and Mr. Ranjan gave further insights to us with help in statistical analysis. We are grateful to all of them for their professional inputs.

The study team at Manas planned, implemented and completed the study on a war footing. Our Project Manager, Mr. Naveen Kumar, along with Ms. Monica Kumar and Mrs. Mridula Apte, were the Consultant Psychologists and Dr. Amiya Banerjee was the Consultant Psychiatrist.

Manas Team

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Introduction

Mental health is on the verge of emerging as one of the most problematic challenges of the urban world. While depression is estimated to be the second largest cause of disease burden, in our country, the gross lack of awareness and stigma associated with mental health make it an even more frightening scenario.

In the changing urban society where migration, new jobs and breaking of families and old ties has become common place, loneliness and psychological distress are not uncommon. The urbanization brings deleterious consequences for mental health through the influence of increased stressors and factors such as overcrowded and polluted environment, dependence on a cash economy, high levels of violence, and reduced social support. There is considerable stigma attached with mental disorders and ignorance regarding information about mental illness and available help and treatment.

The mental health care in urban areas is at present limited to psychiatric hospitals and departments of psychiatry in medical colleges. Mental health problems at an early stage remain unrecognized and untreated. There is a tendency to conceal even severe psychiatric problems due to stigma. It is proposed to develop models for mental health care in urban areas with focus on extension of mental health care to community level. Increasing the awareness levels of mental health services and reducing the stigma and shame about mental health is one of the most challenging tasks of mental health professionals.

Though several studies on urban mental health services and availability have been done, a consistent lack of mental health professionals over several years make it difficult for the layperson to avail of any services. The latest statistics tell us that there are 2000 psychiatrists, 500 neurosurgeons, 300 psychologists and 300 social workers in the country. In a study[1], it was found that there exists a huge gap of 94% between the demand for mental health services and the available services in Delhi.

In this fast paced world, where mental health concerns are rapidly on the rise and the availability of mental health professionals and resources remains a negligible amount, it is important to understand aspects like the prevalence of psychiatric morbidity, the notion of subjective well being and happiness amongst the general population of the city & the levels of awareness regarding mental health concerns and the help seeking behavior of people with psychiatric and psychological concerns. This data should be important to understand the unique mental health needs of Delhi and planning of resources accordingly.

Review of literature

The review of literature for the present study has been divided into two broad groups

- ***Psychiatric morbidity and subjective well being in the general population***
- ***Mental health awareness and help-seeking behavior.***

Psychiatric morbidity and Subjective well being in the general population

Mental health status, psychiatric morbidity and epidemiology has been studied in India and abroad using various measures ranging from assessment of common mental disorders, subjective reports of distress, psychosomatic symptom assessment, stress indicators to prevalence of major mental illnesses within the community.

Since 1960, epidemiological studies of psychiatric morbidities in different samples of the Indian population have been conducted. The studies have reported varying prevalence rates, ranging from 14 to 102 per 1000 population.[2] Thus, it is seen that the prevalence rates have displayed a wide amount of range, and no trend has emerged. Looking at the data, it can be said that psychiatric morbidity has not increased over the years; however has changed in terms of the kind of disorders. This data is important for planning and delivery of health care services. Table 1 summarizes the results of surveys of psychiatric morbidity in India.

Investigator	Year	Center	Location	Sampling	Population	Prevalence/1000
Elangar *et al*10	1971	Hoogly	Rural	H-H	1393	27
Sethi *et al*	1972	Lucknow	Rural	H-H	2691	39.4
Verghese *et al*12	1973	Vellore	Urban	SRS	1887	66.5
Sethi *et al*	1974	Lucknow	Rural	3SPS	4481	67.0
Thacore *et al*14	1975	Lucknow	Urban	H-H	1977	81.6
Nandi *et al*15	1975	West Bengal	Rural	H-H	1060	102.8
Nandi *et al*16	1979	West Bengal	Rural	H-H	3718	102
Shah *et al*	1980	Ahmedabad	Urban	H-H	2712	47.2
Mehta *et al*18	1985	Vellore	Rural	S-S	5941	14.5
Sachdeva *et al*19	1986	Faridkot	Rural	H-H	1989	22.12
Premarajan *et al*20	1993	Pondichery	Urban	RS	1115	99.4
Shaji *et al*	1995	Erankulam	Rural	H-H	5284	14.57
Sharma	2001	Goa	Mixed	SRS	4022	60.2

Table No: 1

Prevalence of Psychiatric morbidity in India (Source [2])
H-H- house to house survey; S-S – systematic sampling; SRS – stratified random sampling, 3SPS- 3 stage probability sampling; RS- random sampling[3]

A meta-analysis of 13 psychiatric epidemiological studies [3], with a total sample size of33, 572 yielded an estimated prevalence rate of 5.8%.

- Organic psychosis (0.04%),
- Alcohol/drug dependency (0.69%),
- Schizophrenia (0.27%),
- Affective disorders (1.23%),
- Neurotic disorders (2.07%),
- Mental retardation (0.69%)
- Epilepsy (0.44%)

Psychiatric morbidity was found to be correlated with urban residence, gender, age group (35-44 years), and marital status (married/widowed/divorced), low socioeconomic status and nuclear family type. In 1966, the Mental Health Advisory Committee to the Govt. of India suggested a prevalence rate of mental illnesses of 20 per 1000 population with 14 per 1000 in rural areas.

Ganguly (2000) did an analysis on such studies. He noted that the national prevalence rates for all mental disorders arrived at are: 70.5/1000 (rural), 73/1000 (urban) and 73/1000 (rural+ urban). Urban morbidity in India is 3.5 per cent higher than the rural rate. But it varies for different categories of diseases [4]. A study assessed changes in mental health status within the community over a 20 year period; of prevalence of psychiatric morbidity in 2 villages in West Bengal with a sample size of 3488. They reported that total morbidity was 105.2 per 1000, among males it was 73.5 per 1000 and among females it was 138.3 per 1000. They found that rates of anxiety, hysteria and phobia had fallen dramatically while those of depression, learning disability and dementia had risen significantly from 1972 to 1992 [5].

Madhav (2001), in an analysis of ten Indian studies on psychiatric morbidity concluded that prevalence rates for all mental disorders was observed to be 65.4 per 1000 population. Prevalence rates for schizophrenia, affective disorders (depression), anxiety neurosis, hysteria and mental retardation were 2.3, 31.2, 18.5, 4.1 and 4.2 per 1000 population respectively. The urban morbidity rate was 2 per 1000 higher than the rural rate. He also observed that the prevalence of schizophrenia (2.3/1000) is the only rate whose prevalence is consistent across cultures and over time while depression and anxiety neurosis are the most widely prevalent disorders [6]. It has been seen that rural epidemiological studies are more difficult to conduct as compared to urban ones, due to ignorance, stigma and lack of resources [2]. Many disorders like substance abuse/ dependence, obsessive compulsive disorder often go unaccounted due to ignorance and attribution of such issues to personality factors. Visible mental disorders like Epilepsy and hysteria are accounted in a more reliable manner and are significantly more common in rural communities [3].

In the rural population, domestic violence and suicide are some of the other mental health issues that need specific attention. [7]

Age, has been seen to be an important determinant of psychiatric morbidity. Rao (1993) reported that mental morbidity was present in 8.9% of the elderly (above 60 years); with depression being the most common disorder (6%) [8]. Community surveys of psychiatric morbidity [9] in India revealed a peak incidence of psychiatric disorders in middle age and a fall in old age[10]. In a study by Tiple et al., (2006), the highest prevalence of psychiatric morbidity was found in sixth and seventh decades

of life. Family joint ness was adequate in the majority of patients. Objective social support was moderate for the majority of patients coming to hospital but perceived social support was poor [10].

Children and adolescents also form a substantial part of the psychiatric population in our country. In an epidemiological study on rural and urban children in Bangalore, Srinath et al., (2004) concluded that the prevalence rate of psychiatric disorders for children in the age group of 0-16 was 12.5 % with diagnosis of Expressive Language Disorder, Oppositional defiance disorder, Attention Deficit Hyperactivity disorder, Mental Retardation, specific phobia, hyperkinetic disorders, stuttering being the most common. Prevalence rates of psychiatric morbidity in 0-16 yr old children in India were found to be lower than Western figures. Middle class urban areas had highest and urban slum areas had lowest prevalence rates. Assessment of felt treatment needs indicated that only 37.5 per cent of the families perceived that their children had any problem. Physical abuse and parental mental disorder were significantly associated with psychiatric disorders [11]

Gender is yet another important determinant of mental health issues and disorders, in contrast with world statistics; it has been observed that in India, women have more psychiatric morbidity as compared to their male counterparts. This can be attributed to reasons like lack of opportunities, suppression, violence/ abuse, patriarchal society etc. This higher rate is consistent for both urban and rural areas as well as across regions, religions and socio-economic classes. Depression is the most prevalent mental health problem among women in India as it is elsewhere. (Carstairs & Kapur, 1976; Kapur & Singh 1983; Kapur and Shah 1991; Daver 1999). In an earlier study Carstairs and Kapur (1976) also reported an increase in psychological distress as a result of changes in the family organization [12]. Chakraborthy (2001), on the basis of a field study conducted in Calcutta, reported some important correlates of common mental disorders in women. Age, marital status, economic status, occupation, education and family roles comprise these correlates. Neuroses increases with age for both genders but women have a much higher rate. Single women were found to have less illness compared to single men. The ratio was equal for married couples but widowed females had higher rates of illness [13].

Rodes et al (2001) in a study analyzed gender differences in the use of out patient mental health services and found that women had more mood/anxiety disorders than men and men were characterized by more substance abuse and antisocial behaviour. Men were also more likely to have a combination of both types of disorder [14]. In a recent report by the WHO, it has been seen that males have a higher incidence of mental health issues and disorders in childhood, characterized by disorders like Attention Deficit Hyperactivity Disorder, Oppositional Defiance Disorder, Conduct Disorder and Learning Disability. In adolescence, females have a higher rate characterized by Depression, self harm and eating disorders. Adolescent males pose a higher incidence of substance abuse. In adulthood, the rate of depression is higher for females. Schizophrenia and Bipolar disorder have equal prevalence rates for both men and women. In old age, again females have a much higher rate of psychiatric morbidity marked by disorders like Depression, Dementia and Psychosis.

Socio- economic factors and psychiatric morbidity have also been extensively researched, Psychiatric epidemiological surveys since the late 1930s have reported higher rates of mental illness in low-income communities. Early studies showed this in major mental illnesses like schizophrenia. Recent evidence suggests this is the case with other groups of psychiatric disorders as well. The National Comorbidity Survey (NCS) concluded that individuals with low socio

economic status demonstrate higher risk for Mood disorder than individuals who are economically well-off. Bipolar affective disorder on the other hand is reported to occur more in the upper socio-economic strata. "Common Mental Disorders" (CMDs), are reported to be most prevalent among those with the lowest material standard of living, especially among those with a long-term experience of poverty .The explanatory models of persons suffering from common mental disorders have been described in a number of studies, in all of which poverty and socio-economic problems have been cited as one of the most important factors causing emotional distress. The high incidence rate of psychiatric disorders in the lower economic strata is due to a number of factors like low income, insecurity, social change, hopelessness, lack of education etc.

Subjective Well-Being (SWB) refers to how people evaluate their lives, and includes variables such as life satisfaction and marital satisfaction, lack of depression and anxiety, and positive moods and emotions. The idea of SWB or happiness has intrigued thinkers for millennia, although it is only in recent years that it has been measured and studied in a systematic way. Happy people are more likely to see the bright side of affairs, pray, directly struggle with problems, and seek help from others, whereas unhappy people are more likely to engage in fantasy, blame others and themselves, and avoid working on problems (McCrae & Costa, 1986). SWB, though not the same as happiness in a strict sense, does comprise several notions typically associated with happiness and the good life[15]. Specifically, SWB is 'a broad category of phenomena that includes person's emotional responses, domain satisfactions, and global judgments of life satisfaction' [16].

Specifically, reported SWB consists of two distinctive components an *affective* part, which refers to both the presence of positive affect (PA) and the absence of negative affect (NA), and a *cognitive* part [17].

Since the emergence of the field over five decades ago, the SWB literature has progressed rapidly. Forsell (2004) found that people with low wellbeing had a high meet-able need for care [18]. They were also more likely to fulfill the criteria for psychiatric disorders. Better well being was associated with certain age groups and it wavers with gender, educational and socio-economic status. High social support was associated with better well being and so was higher age [19]. Mohammad et al (2002) report contrasting findings. In their study on Keralite men and women, they found poor wellbeing with advancing age and specific gender differences in the same[20]. While wellbeing seemed to fluctuate between ages 25-55 years, a steady, positive wellbeing was perceived by most men after age of 55 years. However, for women, a decline after 55 years of age was seen. This could be explained by higher risk for widowhood, health problems at later ages, all leading to poorer self-concept (Pinquart & Sorensen, 2001)[21].

Education seems to increase not only wellbeing, but also psychological awareness. In response to questions on subjective mental health, men with higher education reported their stress in terms of anxiety and nervous breakdown, while those with lesser education reported more physical symptoms to explain their stress (Bryant & Marquez, 1986)[22]. Research on factors like unemployment and inflation playing a role in SWB has been conducted. In particular, unemployment is found to affect SWB through two channels: it has a direct negative effect on people who lose their job (keeping income constant), and an indirect negative effect on the entire population (higher risk of losing a job) [23, 24, 25, 26].

Mohamed et al. (2002)[2O] reported that educational attainment of the individual, martial status, quality of housing, availability of electricity, gender, age, religion, region of the state where the person lives and employment status are found to be significant factors which affect well being of the individuals. However, migration status of the households has no significant impact on well being. In a study by Cummins et al., (2003)[27] in Australia it was observed that people in country areas were more satisfied with their personal lives than city-dwellers, but less satisfied about the national situation. People who had recently experienced a strong positive event evidenced a rise in wellbeing, whereas those who had experienced a strong negative event evidenced wellbeing in the low-normal range. It has also been seen that high spiritually oriented people experience greater SWB as compared to less spiritually oriented people [28].

In an interesting study, it was found that people in poor nations show lower average SWB scores. Countries that are wealthier possess greater freedom and human rights, and an emphasis on individualism, and have citizens with higher SWB [29, 30.]

Individualistic cultures are those that emphasize the individual – his/her autonomy, motives, and so forth. In contrast, in collectivist cultures, the group (e.g., the family) is often considered more important than the individual. There is an emphasis on harmonious group functioning, and the belief that the individual's motives and emotions should be secondary. In individualistic nations, reports of global well-being are high, and satisfaction with domains such as marriage are extremely high. Nevertheless, suicide rates and divorce rates in these same individualistic nations are also high [31]. It may be that people in individualistic nations make more attributions for events internally to themselves, and therefore the effects are amplified when things go either well or badly. It might also be that individualists are more able to follow their own interests and desires, and therefore more often find self-fulfillment. At the same time, there may be less social support in individualistic cultures during troubled periods. Furthermore, individualists are more likely to get divorced, or even commit suicide, if things do not go well. Thus, individualists may experience more extreme levels of SWB, whereas collectivists may have a safer structure that produces fewer people who are very happy but perhaps also fewer people who are isolated and depressed.

On the contrary some studies, suggest that personality and SWB are strongly related [32]. This implies, as some researchers feel that the understanding the individual personality is extremely important to explain SWB. Notably, this helps the happiness paradox, that as some countries become very wealthy; SWB fails to improve or even declines.[33]. In a recent research Hoorn, (2007) has given the determinants of SWB, classifying them in six broad groups: (i) personality factors; (ii) contextual and situational factors; (iii) demographic factors; (iv) institutional factors; (v) environmental factors; and (vi) economic factors [34].

Thus, we see that the literature on SWB has emphasized the joint importance of personality, the social environment and circumstances in determining levels of subjective well-being. Special attention has also been paid to the importance of goals and aspirations, of comparison groups, personal experience, and habituation as joint determinants of how changes in circumstances will affect individual well-being.

Mental health awareness and help-seeking behavior

Increasing awareness about mental health services and reducing the stigma and shame attached to mental health is one of the most challenging tasks for the mental health professionals. This can only be achieved if we have a clear picture about its prevalence and the obstacles one is likely to encounter in doing so. Some of the researches that can show us the direction are reviewed below.

Researches have focused on studying attitudes towards mental illness. A large scale significant study by Barry et al (2000) assessed awareness, current practices, attitudes, stigma about depression and suicide among the population in Ireland, indicated clear gender differences. Men below 40 years of age had lower levels of awareness, perceived more social stigma, less confidence in dealing with mental health issues, negative attitudes towards help-seeking, while women were more positive, had several informal social support networks, were open to dealing with mental health issues[35].

It has been seen that 'everyday' thinking about mental illness extends far beyond diagnostic characteristics of mental illness. It relies more on the subjective interpretations and meanings that individuals assign to symptoms and illness. In a recent study, Maurya & Dixit (2008) have explored the perceptions of people towards mental illness. It was seen that differences emerged in terms of gender, where most of the male respondents attributed mental illness to workplace issues, females attributed it to family and relationship issues. In general people were aware about mental illness and its consequences; however they were rarely aware as to how mental health could be maintained [36]. In traditional cultures and pre- modern cultures, traditional ideas as well as common sense practical notions are closely related to socio-cultural conceptualizations of religion, magic, purity and danger. Mental illness in cultures like India is often associated with evil forces.

Studies like Wagner (1999) have also highlighted the existence of cultural beliefs in India pertaining to ghosts and spirit possession as responsible for madness. According to respondents in this study, the less severe patients were termed as people with mental illness and when the severity increased it was termed as madness [37]. Due to the above reasons the stigma associated with mental illness is enormous. Stigma can be considered as an amalgamation of three related problems: a lack of knowledge (ignorance), negative attitudes (prejudice), and excluding or avoiding behaviours (discrimination). In relation to knowledge about mental illness it is clear that there are striking knowledge gaps [38].

Awareness and Stigma are closely related to help seeking behavior for mental health concerns, stigma against people with mental illness is a major barrier to help-seeking in people with mental health problems. The threats of diminished self- esteem and of public identification when labeled 'mentally ill' dissuade people from treatment and seeking appropriate help [39]. The general public seems to infer mental illness from four cues: psychiatric symptoms, social skills deficits, physical appearance, and labels [40]. Many of the symptoms of severe mental illnesses like psychoses – for example, inappropriate affect and bizarre behaviour are manifest indicators of psychiatric illness that produce stigmatizing reactions [41].

In India a wide range of professionals including psychiatrists, psychologists, general physicians, faith-healers and religious healers cater to the needs of mentally ill patients. Psychiatric facilities are available at general hospitals, office based practice and mental hospitals. Psychiatrists are

preferred the least due to stigma. However, even if people want to willingly seek professional help, they are often unable to do so, due to a severe shortage of professionals and facilities. There is only 1 trained psychiatrist for every 100,000 people with a mental illness. Most (75%) mentally ill patients live in villages, where access even to basic health care is difficult. Half (53%) of the state-run psychiatric hospitals do not have a rehabilitation program [42]. The statistics of availability of psychiatric beds and mental health professionals for India have been given in Table 2.

Psychiatric Beds per 10,000 population	
Total psychiatric beds	0.25
Psychiatric beds in mental hospitals	0.2
Psychiatric beds in general hospitals	0.05
Psychiatric beds in other settings	0.01
Professionals per 100,000 population	
Number of psychiatrists	0.2
Number of neurosurgeons	0.06
Number of psychiatric nurses	0.05
Number of neurologists	0.05
Number of psychologists	0.03
Number of social workers	0.03

Table No: 2

Psychiatric Beds and Professionals in India (Source: WHO)

The country's mental health budget does not exceed 1% of total health expenditures. The National Mental Health Programme was implemented to provide services to rural as well as urban populations, but 80% of people in rural areas cannot access its services. Health and labour policy-makers, insurance companies and the general public all discriminate between physical and mental health problems. Mentally ill patients are being systematically and continuously ignored and denied the social rights they deserve.

Chaddar et al., (2001) studied the help seeking behaviour of psychiatric patients in Delhi, they concluded, that a wide range of services were used by the subjects varying from professional care to faith healers. Trust, easy availability and accessibility, recommendations by the significant others and belief in supernatural causation of illness were the important reasons for choosing a particular facility [43]. Thus socio-cultural factors appeared to influence the help seeking behavior and that a substantial number of patients suffering from severe mental disorders seek non-professional care.

The use of complementary medicines and consultations with traditional healers is widely acknowledged in low income countries, such as India. Here too the limited availability of health services motivates the use of a wide range of alternative systems of care for various ailments,

including mental illnesses. In addition to herbal and other traditional medicines, healers and healing temples are seen as providing curative and restorative benefits. In a study conducted by Raguram et al. (2002) on traditional healing, it was seen that the subjects generally acknowledged benefits of their stay at the temple[44]. In addition the family caregivers of these patients also thought that most of the subjects had improved during their stay. Thus, they identified improvement in the symptoms of people with psychotic illnesses who received no psychopharmacological or other somatic interventions during their stay in this temple.

The cultural power of residency in the temple, known for its healing potency, may have played a part in reducing the severe psychotic symptoms of these subjects. They also noted that in addition to the specific healing power associated with the temple, the observed effects may have also resulted from the supportive, non-threatening, and reassuring setting. It has been seen that individuals prefer seeking help when they are allowed the safety of anonymity. Seeking help in identifiable conditions might cause feelings of inefficacy, smallness and dejection [45.] Apart from being affected by anonymity and identifiably, help seeking has also been found to be significantly influenced by locus of individuals need attribution i.e. internal and external [46].

It has been seen that males seek less help as compared to females. The examination of each sex leads to the conclusion that males are generally dominant, assertive, independent, and competent and self- reliant. In contrast females are generally described as warm, sensitive, weak and dependent[47]. Thus, the self esteem of males suffers more in comparison to females in terms of help seeking behavior for mental health concerns.

Methodology

The Present Study

In this study, our endeavour has been to study the mental health status and sense of well being amongst the general population in Delhi. An attempt has been made to understand how much psychological distress is faced by the general population as well as to have some indicators of the prevalence of psychiatric morbidity in the city. It has also been interesting in this context to study what dimensions of well being are perceived by most Delhites as positive.

In this study, an attempt to explore the help-seeking behaviours of people, when faced with mental distress and disturbance is made. In the face of lack of knowledge and lack of adequate professionals, do local healing practices play a role? Do people find them beneficial?. Answers to these questions will give indication of the help-seeking behavior of the general public in Delhi.

At the end, we have made an attempt to evaluate levels of awareness of mental health amongst the population of Delhi through a representative sample of local influencers, such as pundits, maulvis, astrologers, faith healers, leaders, and teachers and so on, who are agents of social change, by engaging them in Focus Group Discussions (FGDs). Completion of this process has aided in increased awareness about mental health in the general public. Distribution of Information, Education, Communication (IEC) material and discussions to generate awareness and dispel myths have been conducted. The study has been conducted with the following objectives in mind:

OBJECTIVES

- To assess the prevalence of psychiatric morbidity and psychological distress among the general population.
- To assess the subjective well being among the general population.
- To study the overall mental health status by exploring the relationship between psychiatric morbidity and subjective wellbeing.
- To study the patterns of help-seeking behaviours of the general population in the context of mental health needs.
- To explore the awareness about mental health issues and utilization of services in the general population.
- To study the relationship between awareness and utilization of mental health services.
- To contribute in generating awareness about mental health issues and provide accurate information about mental health.

VARIABLE OF THE STUDY

Socio-Demographic Variables*:* such as Age, Gender, Marital status, Education, Occupation, Occupational status, Socio-economic status, Income, Family Type, No. of Children are considered in the study.

Psychiatric Morbidity*:* this refers to the disability and burden, that having a psychiatric illness imposes upon the patient and his family.

Subjective Wellbeing*:* Subjective Well Being is a composite measure of independent feelings about a variety of life concerns in addition to an overall feeling about life in positive and negative terms.

Help-Seeking Behavior*:* this refers to the steps people take when they experience any emotional, mental, psychological and physical (psychosomatic) complaint.

Mental Health Awareness*:* refers to knowledge people have about -

What is mental health/ Health Vis-à-vis Physical and mental health
Symptoms of mental illness/ Mental distress and disorders
Causes of mental illness
Accessibility, affordability availability of mental health services
What can enhance mental health and wellbeing
Treatment possibilities for mental health problems and difficulties
Local help-seeking behaviors and their benefits
Stigma associated with mental health problems and difficulties

APPROACH

The study was divided into 2 levels:

Level 1 focused on the first four objectives, namely assessment of mental health status, wellbeing and help-seeking behaviors and this constituted the quantitative part of the study.

Level 2 focused on understanding the level of awareness amongst the general population and facilitating the generation of the same by engaging in Focus Group Discussion with opinion makers and other influential people of the society. This was the qualitative part of the study that makes it more humane rather than a mechanical survey.

Level 1- PRIMARY SURVEY (Quantitative)

The first level of the study aimed at assessment of mental health status of the general population along with their subjective wellbeing and the help-seeking behaviours that they employ whenever they are faced with psychological distress or disturbance of any kind.

TOOLS

4 tools were used in data collection for Level I (Quantitative Survey):

1. General Health Questionnaire – 12 (GHQ-12)
2. Subjective wellbeing Questionnaire (SUBI)
3. Help-seeking Behaviour Questionnaire (self developed)
4. Socio-demographic data face sheet

DATA COLLECTION

Data was collected through a survey, by a team of ten educated research investigators. Some Psychology interns as well as volunteers who were interested in being a part of the research team were hired for data collection. The team of research investigators was oriented and trained by Manas team of professionals for a period of two weeks prior to commencement of data collection.

Training included the following:

a) Objectives of the research were clarified
b) Interview skills required were imparted using mock interviews
c) Step by step understanding of the questionnaire
d) Ethical issues like; confidentiality etc were explained.

These professionals visited the assigned areas and introduced themselves and the purpose of the study. After obtaining verbal consent from the participants, and assuring them of confidentiality, they administered the questionnaires, one-by-one, carefully in the order explained to them. They were present at the time of filling-up questionnaire and they did not leave the questionnaire with anyone. The Project Director and Senior Researchers monitored the field work by regularly visiting the different sites where the survey was being conducted. These measures maintained the sanctity of the study and its results.

SAMPLE

Systematic sampling technique was used to collect data. From each of the 70 assembly constituencies, one ward was randomly selected, from which 35 people were selected through systematic sampling from the list of households drawn from the voters list of the respective wards. The total sample size was 2381

Sl NO	Name of AC	Respondents	Sl NO	Name of AC	Respondents
1	Sarojini Nagar	35	36	Badarpur	35
2	Gole Market	32	37	Trilok Puri(SC)	35
3	Minto Road	34	38	Patpar Ganj(SC)	35
4	Kasturba Nagar	31	39	Mandawali	35
5	Jangpura	35	40	Geeta Colony	35
6	Okhla	35	41	Gandhi Nagar	35
7	Kalkaji	35	42	Krishna Nagar	35
8	Malviya Nagar	32	43	Vishwash Nagar	32
9	Hauz Khas	32	44	Shahdara	35
10	R.K.Puram	34	45	Seemapuri(SC)	31
11	Delhi Cantonment	33	46	Nand Nagari(SC)	35
12	Janak Puri	35	47	Rohtas Nagar	35
13	Hari Nagar	35	48	Babarpur	35
14	Tilak Nagar	35	49	Seelampur	35
15	Rajouri Garden	32	50	Ghonda	35
16	Madipur(SC)	35	51	Yamuna Vihar	35
17	Tri Nagar	31	52	Qarawal Nagar	35
18	Shakurbasti	35	53	Wazirpur	32
19	Shalimar Bagh	35	54	Narela(SC)	35
20	Badli	35	55	Bhalswa Jahangirpur	33
21	Sahibabad Daulatpur	35	56	Adarsh Nagar	34
22	Bawana(SC)	35	57	Pahar Ganj	35
23	Sultanpur Majra(SC)	32	58	Matia Mahal	32
24	Mangolpuri(SC)	35	59	Balli Maran	35
25	Nangloi Jat	35	60	Chandni Chowk	35
26	Vishnu Garden	33	61	Timarpur	35
27	Hastsal	35	62	Model Town	31
28	Najafgarh	34	63	Kamla Nagar	32
29	Nasirpur	35	64	Sadar Bazar	35
30	Palam	35	65	Moti Nagar	35
31	Mahipalpur	35	66	Patel nagar	35
32	Mehrauli	32	67	Rajinder Nagar	30
33	Saket	35	68	Karol Bagh(SC)	35
34	Dr. Ambedkar Nagar(SC)	31	69	Ram Nagar(SC)	34
35	Tughlakabad	35	70	Baljit Nagar(SC)	32
			Total		2381

Table No: 3

ANALYSIS TECHNIQUE

The relationship of each independent variable with the result drawn was examined by using bi-variate and multivariate analysis technique.

In bi-variate analysis, effects of each independent variable on the dependent variables are obtained without controlling other variables. So the effect of other variables gets inter-mingled leading to no definite conclusion about the relationship.

Multi-variate analysis help in establishing the interrelationship of important factors more accurately, keeping control on all other explanatory variables.

Level 2- FOCUS GROUP DISCUSSIONS (Qualitative)

Methodology for Organizing the FGD:

For the Purpose of gauging awareness, A sample of 15-20 members from each electoral district was selected. These were local influential people in community who were considered to be the representative of community. 2 Members from the each of the electoral wards selected for level 1 were included in the sample. The sampling was random.

Structure

FGD was used to level 2 of the research. One FGD was conducted in each respective sample districts. The specific venue to each FGD was in the district itself.

The duration of each FGD was 60-90 minutes. The following issues were taken up for the discussions.

Objective of FGD

Focus group discussions (FGD) were conducted to fulfill the following objectives:

1. To understand from local groups and local influencers about their mental health awareness and understanding of mental illness (MI)
2. To gauge the level of stigma towards mental illness prevalent in society.
3. To understand the kind of stressors people in Delhi face.
4. To understand factors contributing to perceptions of happiness/ wellbeing in the people of Delhi
5. To assess the various help- seeking behaviours of the people in case of Mental Health concerns.
6. To dispel myths, decrease stigma and create awareness by dissemination of information on Mental Health in a clear simple manner.

Sample

One FGD was conducted in each of the 9 districts of Delhi. The specific venue of each FGD was in the district itself to ensure maximum participation

Sl No	District	Religious Leaders	Teachers	Government Official	Professionals	Doctors	Community Leaders	RWA	Housewives	Total
1	New Delhi	0	2	4	2	2	2	2	2	16
2	South Delhi	2	2	2	2	3	2	4	1	18
3	South West	2	3	2	1	1	2	3	3	17
4	North West	2	2	1	2	1	1	2	2	13
5	East Delhi	1	3	5	3	4	3	3	5	27
6	North East Delhi	2	1	2	1	1	2	2	1	12
7	Central Delhi	2	0	2	2	2	2	3	1	14
8	North Delhi	2	1	1	1	2	1	1	0	9
9	West Delhi	0	2	1	2	3	5	7	2	22
	Total	**13**	**16**	**20**	**16**	**19**	**20**	**27**	**17**	**148**

Table No: 4

The Proceedings of the FGD:

The session was conducted by Manas experts and a semi structured format was followed.

The FGD lasted for around 1 ½ - 2 hours. Each FGD was recorded on video after group's verbal consent to do so. The facilitator first introduced him/herself; the organization conducting the study (Manas), followed by a brief introduction of the study and its need. The facilitators informed the group that the study was supported by National Planning Commission, Govt. of India and that these FGDs would help greatly in the understanding of Mental Health awareness and help seeking behaviors of people in Delhi.

This was followed by a brief introduction of all the members present After this the facilitator spoke about stress, the fact that stress was an inevitable part of life and to a certain extent necessary for development. The group was asked for various stressors concerning people in Delhi. They were also asked as to what were things that created a sense of well being in this city.

The facilitator slowly lead the discussion to mental health awareness. The participants were asked as to how many people could identify mental health concerns like 'being stressed out' or 'feeling low, 'feeling life was worthless' and how many people were aware of serious mental illness like schizophrenia. Stigma and myths which were one of the biggest concerns were highlighted like visiting a mental health professional, family members with mental illness and some culturally held myths about causes and behavior of mental illness.

The discussion than focused on help seeking behaviors of people with mental health concerns and there family members. It was inquired as to where people frequented in case of a mental health issue, whom they trusted and why. An attempt was made to clear all misunderstandings regarding

mental health and mental illness. This was followed by a brief introduction to the various major mental health concerns like depression and suicide, anxiety disorders, obsessive compulsive disorder, schizophrenia and substance abuse. Childhood disorders were also briefly explained. The distinct roles of a psychiatrist and psychologist were described. Information about various institutes offering help were briefly enlisted.

The discussion ended with suggestions from the group about ways of generating awareness.

Participant's Profile:

The range of age, professional and educational status was varied over the 9 FGDs. Several members from the RWAs were present. Senior citizens came in large numbers, men outnumbered women participants. Doctors, yoga therapists and teachers were amongst the largest group of working people. Those retired from government services and bureaucratic services were also present. Corporate professionals, software professionals were conspicuous by their absence. Businessmen were few but present in some FGDs. A couple of *Pandits* and priests also made it to the discussions. Housewives, teachers and government professionals were amongst the women attending the discussions.

Amongst the participants, some citizens had family members who had undergone a debilitating physical or mental illness and empathized with the concerns of this study. Some wanted to help others and join the 'movement' as they called it. While others simply 'Loved the City' and were concerned about the rising stress levels. All FGDs were well represented by senior RWA members, doctors and advocates. FGDs gave us an opportunity to interact with various groups of people and in each FGD the age range, professional and educational background was unique in some manner.

Results and Discussions

The results will be discussed under the following five headings:

I : Demographics
II : Psychiatric Morbidity
III : Subjective Wellbeing
IV : Help Seeking Behavior
V : Mental Health Awareness and Stigma

SECTION I : DEMOGRAPHICS

Average	
Family Size	6.5
Number of Children	2.5
Male Child	1.5
Female Child	1.5
Earning members	1.8

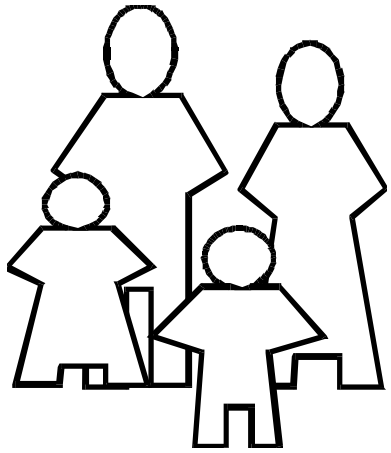


Fig No: 1

The study had a sample size of 2381 respondents. They were drawn from seventy constituencies in Delhi. Each constituency contributed 1 to 1.5% of the total sample.

Men comprised slightly more than half (51.4%) of the sample. The study found average family size of 6.5 members per family, with more than one earning member in each household. 77.1% of the respondents in the study were married.

Women respondents constituted almost half of the sample, were more likely to be married than men (83.3% vs. 71.2%) only 21.3% were single while 1.3% were widowed and 0.4% were divorced.

Single status was significantly more common in men than in women (28% vs. 14.2%).

Widowed status was significantly more common in women as compared to men (2.2% vs. 0.4%).

60% of the sample lived in joint families. The mean family size was 6.5 members, with the mean number of children being 2.5.

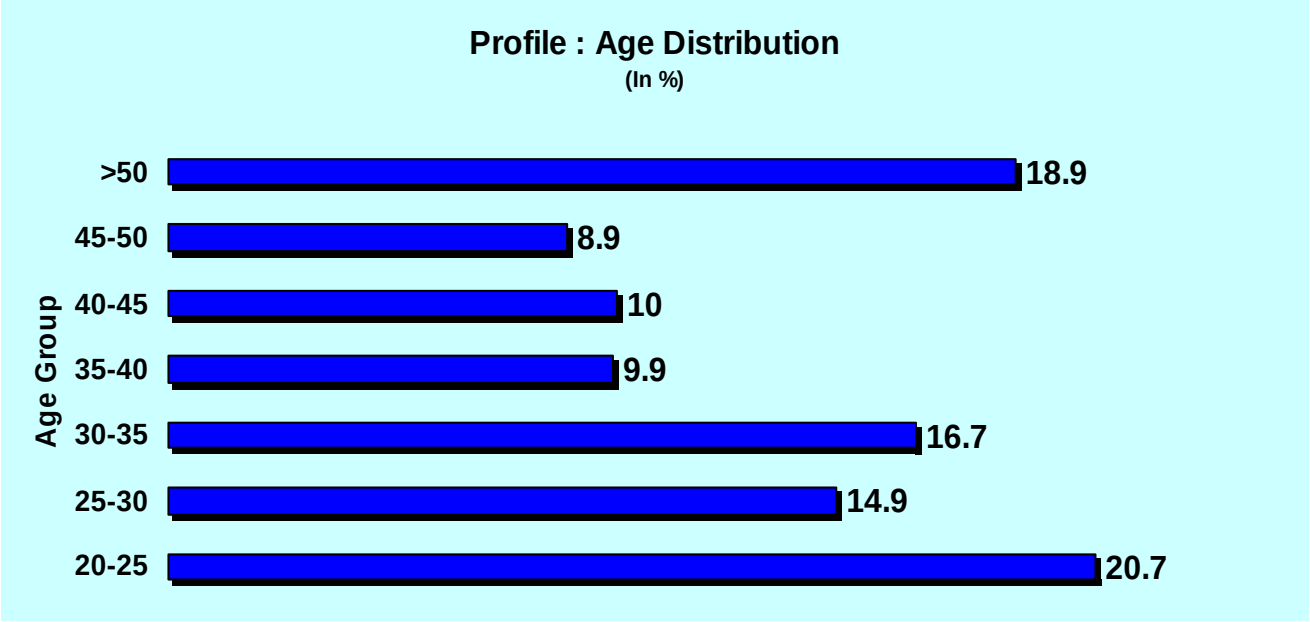


Fig No:2

- The average age of the total sample was 36.3 years.
- Average age of women was more than that of men (36.6 vs. 36.0 years). The age distribution of the sample is shown as above

Profile : Educational Status

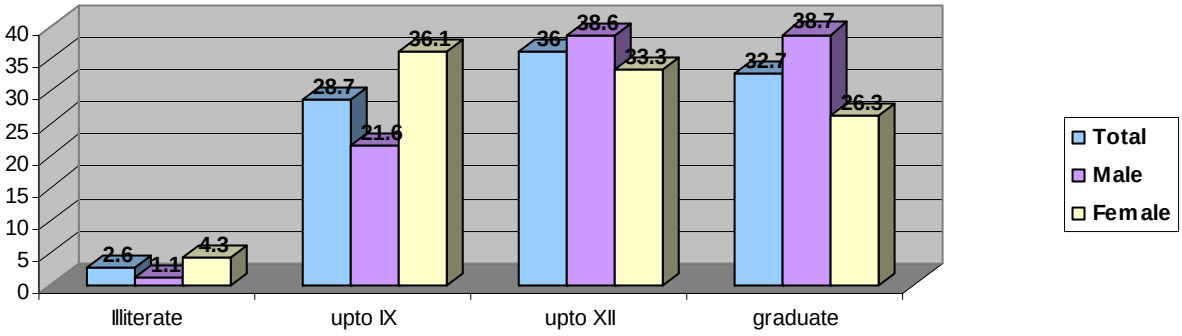
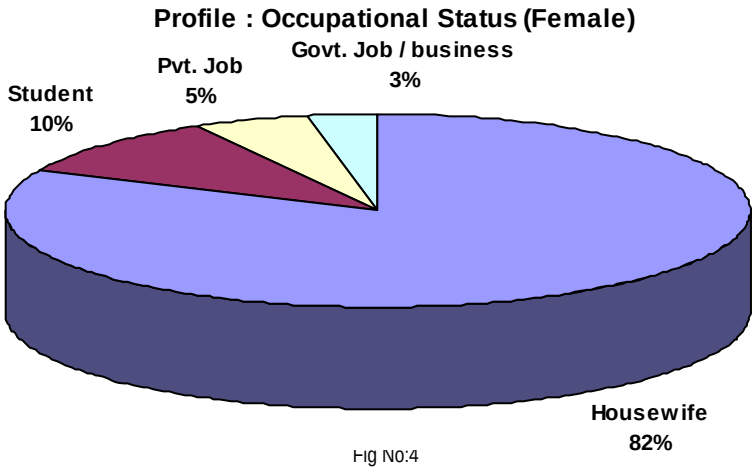


Fig No:3

- As can be seen, women were more likely to be illiterate, while men were more likely to be educated up to XII, or to be graduates.

- There is a significant drop in women's education level after class IX. Girls are expected to take over family responsibilities, and not go out of the house too much, once they grow up.

- Also Added to it 'they will go to another's home, so why should we invest in her further education', 'let her stay at home, help her mother and learn household work'. In the face of these social and family pressures, they tend to drop out of school. In contrast, boys who are in school are encouraged to complete their education.



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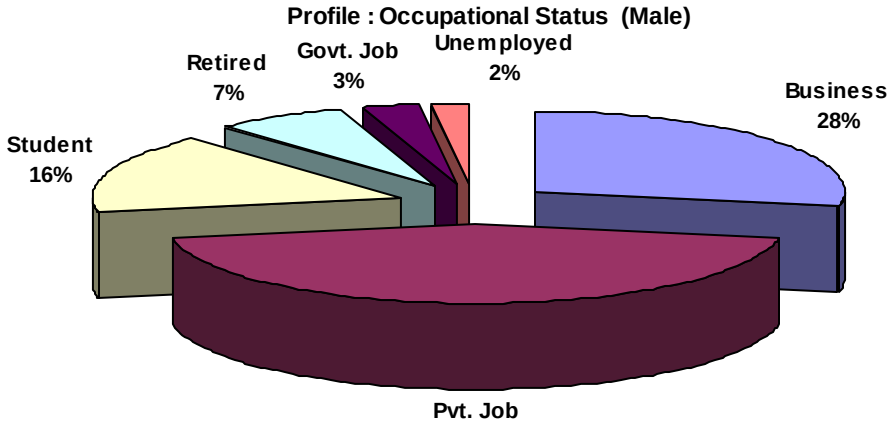

Fig No:5

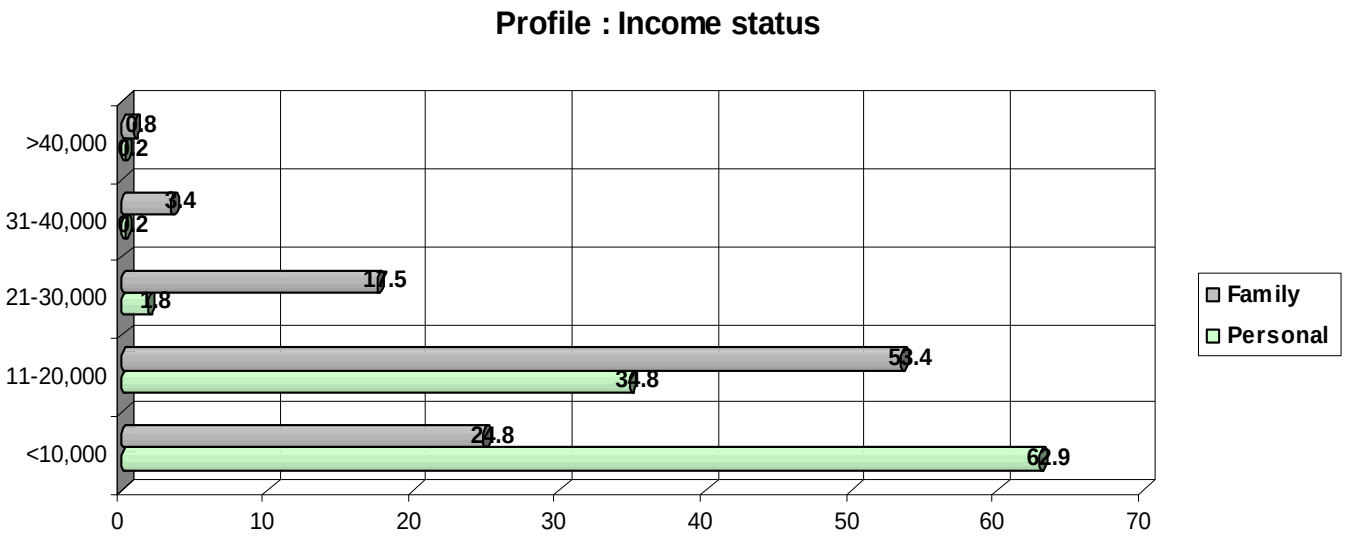

Fig No:6

- The mean monthly personal income was Rs. 8996 and the mean family income was Rs. 15,306 per month.
- The mean number of earning members per family was 1.8.

SECTION II: PSYCHIATRIC MORBIDITY

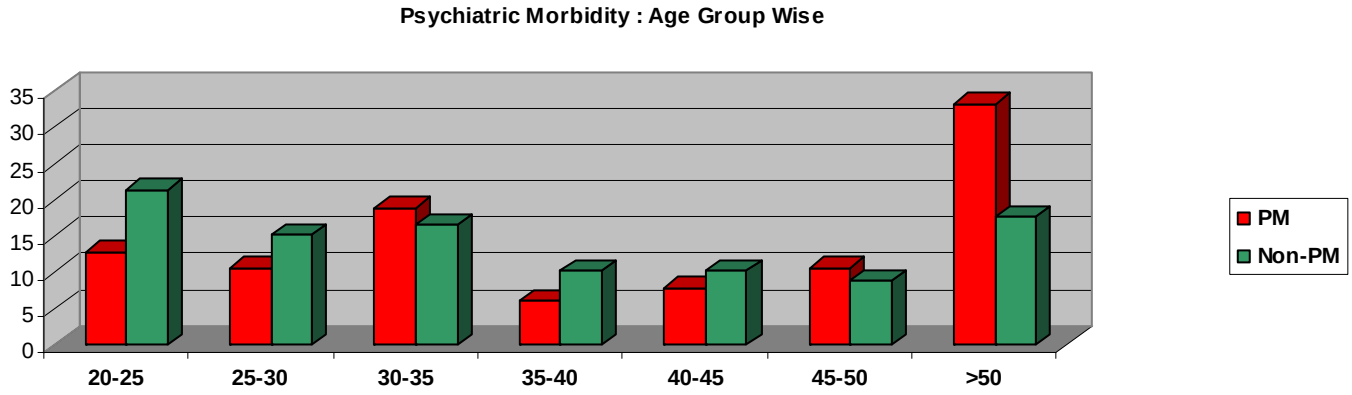

Fig No:7

Group	20-25	25-30	30-35	35-40	40-45	45-50	>50
PM	12.8	10.6	18.9	6.1	7.8	10.6	33.3
Non-PM	21.4	15.2	16.5	10.2	10.2	8.8	17.7

Tabel No:5

P Value > 0.05	No. Sig. Diff. At 95%
P Valuel < 0.03	Sig. Higher at 95%
P Value < 0.05	Sig. Lower at 95%

- The General Health Questionnaire was used to screen for psychiatric morbidity (PM) in the sample. It has 12 items, each with a score of one to four. Any respondent with a score of 3 or more, on three or more items on the scale, was identified as a case i.e. having Psychiatric Morbidity.
- Using these criteria, 180 of the 2381 respondents (7.6%) were identified as having psychiatric morbidity. This prevalence is well in keeping with the prevalence of psychiatric morbidity quoted in previous studies which rage from 1.4 % to 10.2 %
- The male-female sex ratio of the PM group (51.7% vs. 48.3%) did not differ significantly from the sex ratio of the non-PM group (51.4% vs. 48.6%).
- The mean age of the PM group is also significantly higher (40 yrs vs. 36 yrs).
- This is significantly higher PM in the person aged more than years and in the age range of 30-35 Years

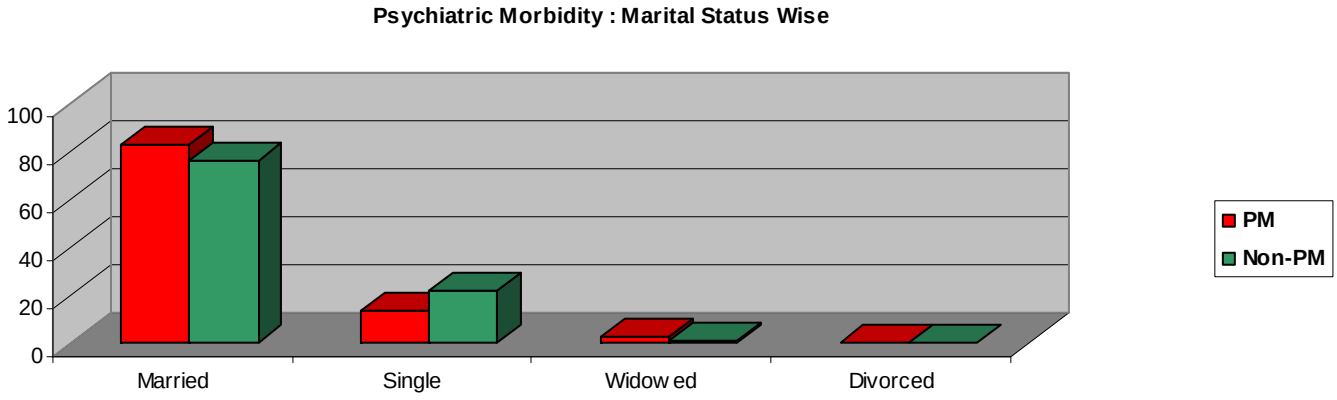

Fig No:8

Group	Married	Single	Widowed	Divorced
PM	83.3	13.9	2.8	0
Non-PM	76.6	21.9	1.1	0.4

Table No:6

P Value > 0.05	No. Sig. Diff. At 95%
P Valuel < 0.03	Sig. Higher at 95%
P Value < 0.05	Sig. Lower at 95%

- The PM group was significantly more likely to be married or widowed, and significantly less likely to be single.
- In part, this could be a reflection of the older age of the PM group

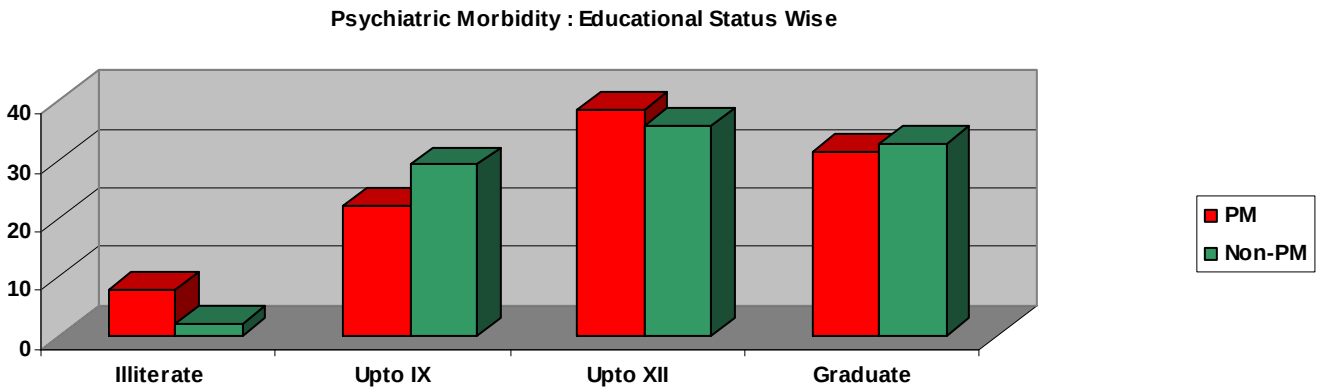

Fig No:9

Group	Illiterate	Up to IX	Up to XII	Graduate
PM	7.8	22.3	38.5	31.4
Non-PM	2.2	29.2	35.8	32.8

Table No:7

P Value > 0.05	No. Sig. Diff. At 95%
P Valuel < 0.03	Sig. Higher at 95%
P Value < 0.05	Sig. Lower at 95%

At first glance, the differences between the two groups do not seem to fall into any meaningful pattern. Some understanding of the evolution of psychiatric over the age span helps to impose some order on these findings. Clinical experience indicates that there are two cohorts within the group of persons with psychiatric problems. The first are those in whom broken or dysfunctional families, inherited disorders and developmental disabilities like attention deficit or learning disability, lead to handicaps from an early age. This cohort either never enters the formal educational system, or drops out within few years, because they cannot keep up with the other children. They either remain illiterate, or do not complete their primary education. This could lead to the significantly higher percentage in the 'illiterates' category, and significantly lower percentage in the 'up to IX' category, in the PM group, as compared to the non-PM group.

The second cohort would have had a normal development and education till their affliction with psychiatric illness in their late teens or early adulthood, which is the common age of onset of these disorders. These persons would have completed their schooling and college by the time the illness affected them, and would contribute to the numbers in the XII pass and graduate groups, in which there are no significant differences between the PM and non-PM group.

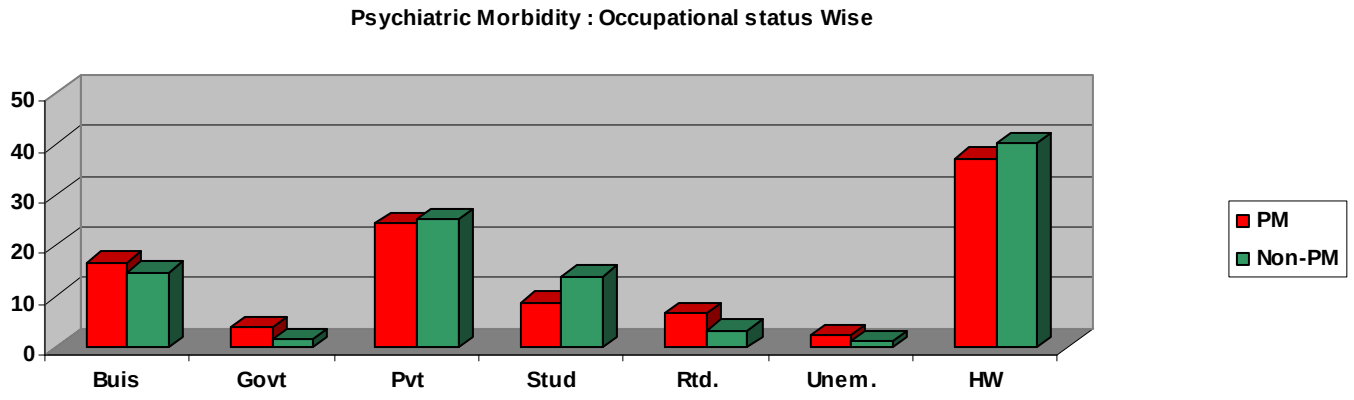

Fig No:10

Group	Buis.	Govt.	Pvt.	Stud	Rtd.	Unem.	HW
PM	16.7	3.9	24.4	8.8	6.7	2.3	37.2
Non-PM	14.8	1.4	25.3	14	3.3	1.1	40.1

Table No:8

P Value > 0.05	No. Sig. Diff. At 95%
P Valuel < 0.03	Sig. Higher at 95%
P Value < 0.05	Sig. Lower at 95%

PM group was significantly more likely to be in business or in government job, and significantly less likely to be students or teachers. They were also significantly more likely to be retired, unemployed or not working. The two groups had comparable numbers in private jobs. Women in the non-PM group were more likely to be housewives.

These findings again support the existence of two profiles within the PM group. One subgroup consists of early onset, serious and disabling morbidity, which leads to higher rates of their not working and being unemployed.

The other subgroup has had normal growth and maturation, and is more likely to be in business or employment.

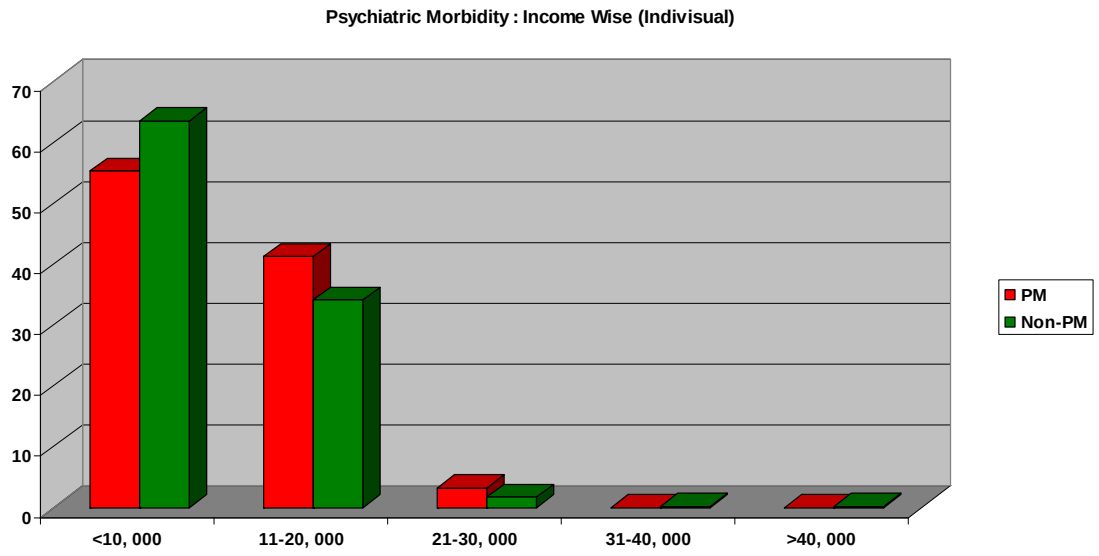

Fig No:11

Group	<10, 000	11-20, 000	21-30, 000	31-40, 000	>40, 000
PM	55.4	41.3	3.3	0	0
Non-PM	63.7	34.2	1.7	0.2	0.2

Table No:9

P Value > 0.05	No. Sig. Diff. At 95%
P Valuel < 0.03	Sig. Higher at 95%
P Value < 0.05	Sig. Lower at 95%

This is also supported by the comparison of monthly income between the two groups in terms of the individual, and the family. As can be seen significantly higher percentage of PM group are found in the higher income group : INR 9799 Vs. INR 8917 in Individual monthly income and INR 16, 394 Vs. INR 15, 217 In Family Monthly Income.

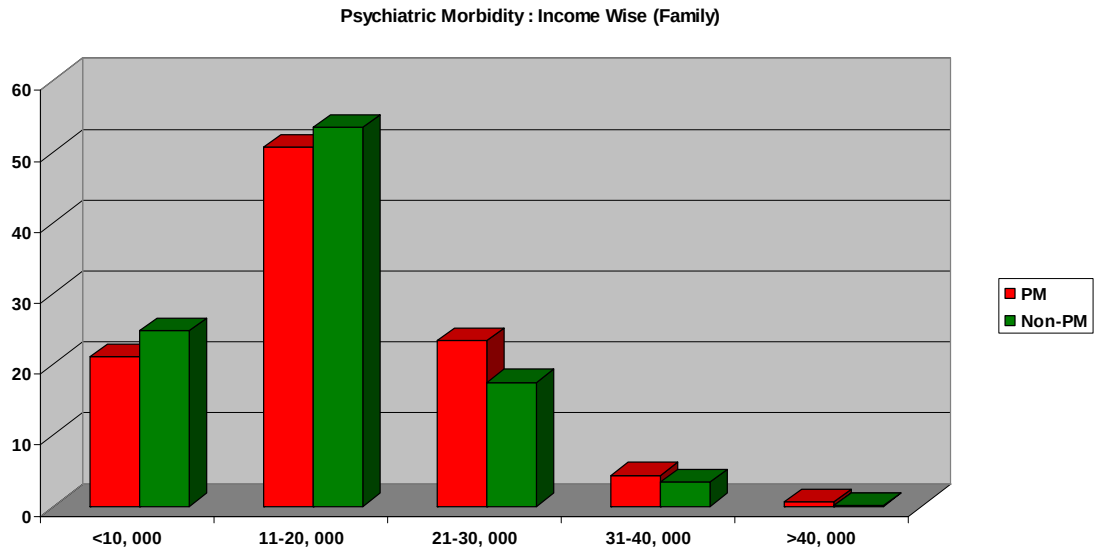

Fig No:12

Group	<10, 000	11-20, 000	21-30, 000	31-40, 000	>40, 000
PM	21.1	50.6	23.3	4.4	0.6
Non-PM	24.8	53.4	17.5	3.4	0.08

Table No:10

P Value > 0.05	No. Sig. Diff. At 95%
P Valuel < 0.03	Sig. Higher at 95%
P Value < 0.05	Sig. Lower at 95%

As most of the income group compressed of <10, 000 to 20, 000 bracket in the study sample The higher income group reported higher PM

SECTION III: SUBJECTIVE WELL-BEING

Subjective well being can be understood as interplay many factors like general well being, positive effect, expectation, achievement, congruence and confidence and coping. It is highly linked with level of perceived stress on the one hand, and the persons coping responses to these stresses, on the other.

Subjective wellbeing of people is measured on the basis of a questionnaire (SUBI) which consists of 9 questions with 3 multiple choices and scores are based on chosen answer. The lower the score the better is the well being of individuals and vice versa.

In this study we have also tried to find the subjective wellbeing and the perceived stress via the FGD's held at 9 districts. The results of the two are presented below.

Part A SUBJECTIVE WELL-BEING (Analysis of SUBI Scores)

In total the survey was conducted on 2381 respondents, drawn from seventy constituencies in Delhi and number of men were 1223 and number of women were1157

Subjective Well Being: Overall mean score

The overall mean score on SUBI is 21.43 which is significantly higher than the median of 18 indicating that Delhi population reports a poor subjective well being. This is collaborated by the focus group discussions responses 9 districts of Delhi where people have reported high levels of stress.

Subjective Well-Being: Gender Comparison

There is no statistical difference found between men and women on SUBI scores, both men and women had high scores indicating poor subjective well being. Men get a score of 21.96 whereas women score 21.69. Women have scored marginally less than men indicating may be they have a better subjective wellbeing than men. They also report a slightly less PM than males (48.3%-51.7%) indicating that women in Delhi have probably a slightly better subjective well being and less psychiatrist morbidity than men.

Sex Wise	Score
Overall	21.43
Male	21.96
Female	21.69

Table No:11

P Value > 0.05	No. Sig. Diff. At 95%

This can be substantiated by the fact most of the women were housewife (82%) and most men were in private job and business (72%). In FGDs, Delhi population has reported high distress over competitive environment and job related hazards and linked it with materialistic wealth and status.

Subjective Well-Being : Age Group Wise Comparison

Across all ages also no statistical differences was perceived. In all ages high distress or poor subjective well being is reported with the age range of 20-25reporting the poorest subjective well being.

Age Group Wise	Score
Overall	21.43
20 to 25	22.05
25 to 30	21.96
30 to 35	21.69
35 to 40	21.96
40 to 45	21.69
45 to 50	21.33
Above 50	21.78

Table No:12

P Value > 0.05	No. Sig. Diff. At 95%

The high score in 20-25 ages indicate that the young population who is at the process of identity formation has high stress levels but is trying to cope with it as the PM score is less in this group.

Subjective Wellbeing : Marital status wise Comparison

There is statistically no difference seen between married, widowed and single on SUBI scores. The subjective well being is poor for married, single and widowed population.

Marital Status Wise	Score
Overall	**21.43**
Married	**21.78**
Single	**22.14**
Divorced	**21.24**
Widowed	**20.97**

Table No:13

P Value > 0.05	No. Sig. Diff. At 95%

The singles have the poorest subjective scores which again is probably because they are a younger lot(poor SUBI scores for age 20-25 years) . The PM is less in this group than married and widowed again reflecting that single population is trying to cope with the situation.

Subjective Well-being: Educational Status Wise Comparison

All the groups have high scores indicating poor subjective wellbeing with no statistical difference.

Educational Status Wise	Score
Overall	**21.43**
Upto 9th	**21.42**
Up to 12th	**21.87**
Up-to Graduate/Post Graduate	**22.23**
Illiterate	**21.06**

Table No:14

P Value > 0.05	No. Sig. Diff. At 95%

Graduates have the poorest well being again reflecting the previous seen trend of young, single in the process of identity formation as more prone to stress.

Subjective Wellbeing: Income wise Comparison

For all the range of monthly income the subject scores reflect a poor well being with no statistical difference but the lowest score in 40.000 above income range which indicates as the materialistic status rises up, the subjective well being is perceived to be better

Income Group Wise	Score	
	Monthly Income Indivisual	Monthly Income Family
Overall	**21.43**	**21.43**
<10000	**21.96**	**21.69**
10000 to 20000	**21.87**	**21.87**
21000 to 30000	**21.51**	**22.14**
31000 to 40000	**20.97**	**21.51**
>40000	**21.96**	**22.23**

Table No:15

P Value > 0.05	No. Sig. Diff. At 95%

Thus across all categories, the subjective wellbeing is poor for the state of Delhi (Overall Mean score 21.43, median is 18). Higher the score, poor is the wellbeing.

As the monthly Income rises the subjective well being becomes better.

Part B : Subjective Well-Being (as reported by people in FGD).

Most members who participated expressed the views that Delhi was indeed much stressed. This is also collaborated by subjective finding where the subjective finding is 21.433% which is on higher side. More the score higher is the distress level. We have divided this section into the perceived stress and confidence in coping and well-being, reported by people.

Perceived Stress

The responses of perceived stress can be categorized in the following category. Some of the most frequently quoted grounds for stress were:

1- HIGH EXPECTATION/ACHIEVEMENT AND LACK OF CONGRUENCE

A	No time/busy schedule
B	Large distances
c	Bad traffic/traffic problems/fights on road due to traffic
D	Increasing materialistic interests of people
E	Jealousy among people
F	Increasing competitiveness-especially for students
G	Less sleep due to certain occupation (like call centre job, shift duties.)
H	Disturbed and erratic routines
I	Too much of superiority –inferiority and hierarchical differences highlighted by people in the city.
J	Work does not get done quickly in government offices, corruption.
K	Migration of people outside Delhi, into Delhi has made the Delhi culture diluted and there is a 'me-first" attitude now.

Table No:16

2- LACK OF BONDING AND COMMUNICATION

A	No time/ busy schedule
B	Lack of communication in family
C	Less bonding with relatives/ friends.
D	Breakdown of joint family.
E	Encouragement to the pub culture drinking habits at younger ages.

Table No:17

3- LACK OF SPIRITUAL/MEDITATION ORIENTATION

A	Lack of spiritual awareness
B	There is no mental nutrition for the mind i.e. people do not normally take active interest in activities to enlighten and relax the mind like creative hobbies as well as meditation.

Table No:18

4- LAWLESSNESS/SAFETY ISSUES

A	Lawlessness, lack of safety and security.
B	Migration of people outside Delhi, into Delhi has made the Delhi culture diluted and there is a "me-first" attitude now.

Table No:19

5- STRESS SPECIFIC TO WOMEN

A	Women had issues besides the ones stated above. Multiple roles left no time at all for one self leading to burn-out. Safety issues and the treatment meted out to women even today all still major stressors.

Table No:20

6- STRESS SPECIFIC TO SENIOR CITIZENS

A	Senior citizens also highlighted a unique set of issues. Dependence on children, motive to interact with them and no time left for one self as they have voluntarily taken over some of the house hold responsibilities to relieve the children. Distances and traffic are stressors they report as very difficult to cope with at this age. Participants gave examples of their lives, or the lives of their busy children to state that one of the major reasons for stress was too much work and no family time. A tendency to compare between earlier years and today was seen throughout the FGDs. The earlier decades were stated to be more relaxed, people expressed and shared concerns in the family- even if they fought, and they bonded well. Today family members don't meet amongst themselves, they don't bond and they don't fight either. Due to busy schedules, there are poor routines, compromised food and sleep schedules and higher amount of irritation, lesser patience.

Table No:21

Senior citizens reminisced the time they were younger and Delhi was a smaller and safer place

7- STRESS SPECIFIC TO CHILDREN

A	Children also find their parents so tired and busy that they feel guilty to share their problems with parents. In effect a whole new generation of children, who internalize problems or share with peers having limited understanding, is being created.
B	Several people blame today's education system- both formal, and the education given at home. They said that there is too much focus on one self, without any morals or spirituals awareness of the inner self. This lead to urgency to gratify all needs, to think selfishly and to think short term.

Table No:22

8- NEED FOR MATERIALISTIC WEALTH

A	Need for materialistic wealth is another important stressor according to most participants. So much so that relationship and people are being compromised for the sake of this wealth. Jealousy and negative comparison with others regarding materials luxuries are phenomena often being reported. People are doing social and economical status comparisons and are unhappy by seeing other people's status/happiness. This statement is echoed in all the 9 FGDs. A significant quotation by one of the participants explained the extent of these issues. ***"People are to be loved"*** ***"Tings are to be used"*** ***"But in today's world there is confusion because"*** ***"People are being used and thing are being loved"***

Table No:23

CONFIDENCE IN COPING AND WELL BEING

Despite the amount of stress, busy schedules, breakdown of bonding and joint families, citizens continue to live and enjoy in Delhi what were the reasons and how did they cope.

1. Being in a metro city was beneficial, most things were well organized, and facilities were adequate in comparison to other cities.

2. Despite everything, RWA members insisted that in most colonies, neighbors could still trust one another and there was a feeling of belongingness.

3. Materialistic aims were fulfilled. This is one reason most people migrated here and if this was achieved, they justified being happy.

4. Right from vegetables to bigger gadgets, there was variety of choice and prices.

5. Individually people reported a sense of wellbeing by committing to certain things in life- like helping at least 1 child get educated, or never blaming others, yoga or seeking spiritual solace.

Subjective Well-Being and Women

This section warrants a special mention as high level of stress was reported by women of Delhi

Women expressed that life seemed all about completion of duties. Most women attending the discussions were over 35-40 years of age. Very few women above 60 were present for the discussion. Probably this is an age where family responsibilities peak and along with a career, work can really take a toll on their health. Several women reported that there is very little time left to socialize or enjoy really. Children's studies, looking after older people and continuously attending to social responsibilities of guests etc. could be pressurizing. To top it all was the need to cater to the "show- off" element of society and continuously upgrade ones possessions.

Working women reported better well being and a sense of role enhancement at the job place. They feel their children consider them as role model and respect them. Their contribution is sought in decision making. However, women gainfully employed outside the home also report a continuous '*bhaga-bhagi*' to workplace, markets and home. Due to this kind of routine, there is lack of sleep and a "hormonal disturbance". Women report that several of them have a problem with hormones due to stress.

They want to get a good job and rise in their careers, they have to try harder to prove themselves and they have to parallely manage the house. Added to that is the guilt of leaving the child in the house alone or with the maid. Women report 'seeing' work in front of them all the time, an inability to enjoy or take out time for themselves. At times they do feel confident that they can cope so well with so many things. However at times they also feel a burn- out and a need to share.

> "***Life is a continuous process of responsibilities, and responsibilities and responsibilities !!!!! I don't remember especially after marriage for how long I have not enjoyed morning sunshine, rain or simple pleasures of life",***
> ***As summarized by one woman***

SECTION IV: HELP SEEKING BEHAVIOR

The help seeking behavior was assessed and gauged into by the quantitative analysis and is substantiated by the findings of the FGDs.

Part A: Help Seeking Behaviour (Quantitative Analysis)

In the first part of this checklist, the questionnaire assessed how many of the subjects reported experiencing common symptoms of emotional disturbance, and what behaviours they engaged in to overcome these symptoms.

218 subjects (9.2%) reported that they or someone in their family had experienced one or more of the nine symptoms listed in the past one year. Within the group of subjects with documented psychiatric morbidity by the GHQ (i.e., the PM group) 62.2% reported experiencing one or more symptoms. In comparison, only 4.8% of the non-PM group reported experiencing any of these symptoms.

However, it is equally notable that as many as 37.8% of the PM group denied experiencing any of these symptoms. This can be understood at several levels. At one level, many persons with psychiatric problems hesitate to reveal their problems when asked directly. This is so because of shame and the fear of stigma. They tend to deny that they have any psychiatric symptoms. At another level, there are some psychiatric disorders where the person is unaware that there is a mental illness; i.e., there is no insight. This group of persons will also deny psychiatric symptoms.

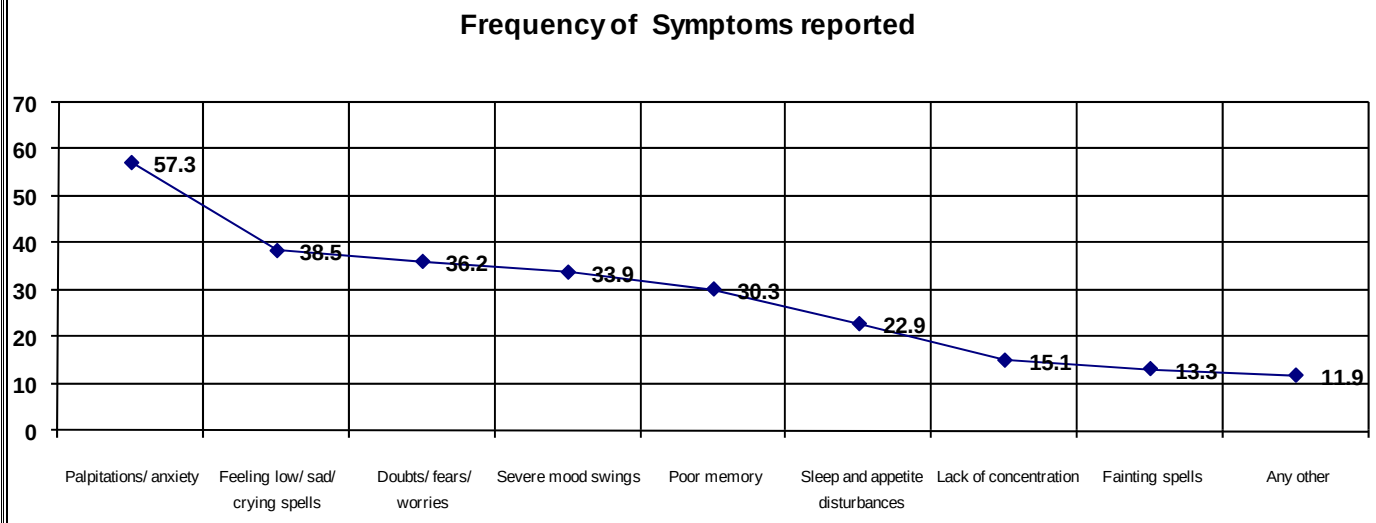

Fig No:13

S No	Frequency of report of symptoms	Value
1	Palpitations/ anxiety	57.3
2	Feeling low/ sad/ crying spells	38.5
3	Doubts/ fears/ worries	36.2
4	Severe mood swings	33.9
5	Poor memory	30.3
6	Sleep and appetite disturbances	22.9
7	Lack of concentration	15.1
8	Fainting spells	13.3
9	Any other	11.9

Table No:24

The above graph shows the distribution of the number of symptoms reported (out of a maximum of nine) by these 2218 respondents. The previous graph shows the frequency at which these nine symptoms were reported. The behaviors that the subjects engaged in, to overcome these

Behaviors engaged in more by the PM group-I

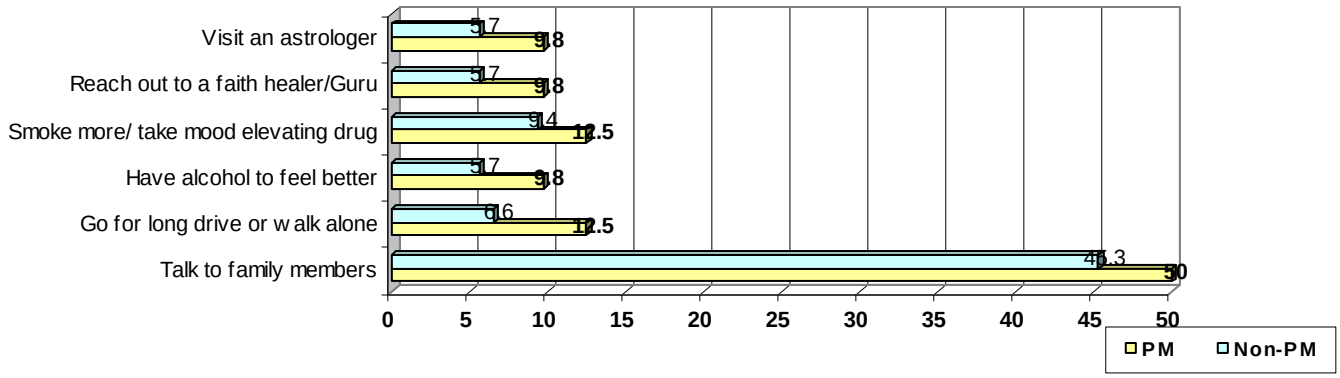

Fig No:14

Behaviors engaged in more frequently by the PM group : II

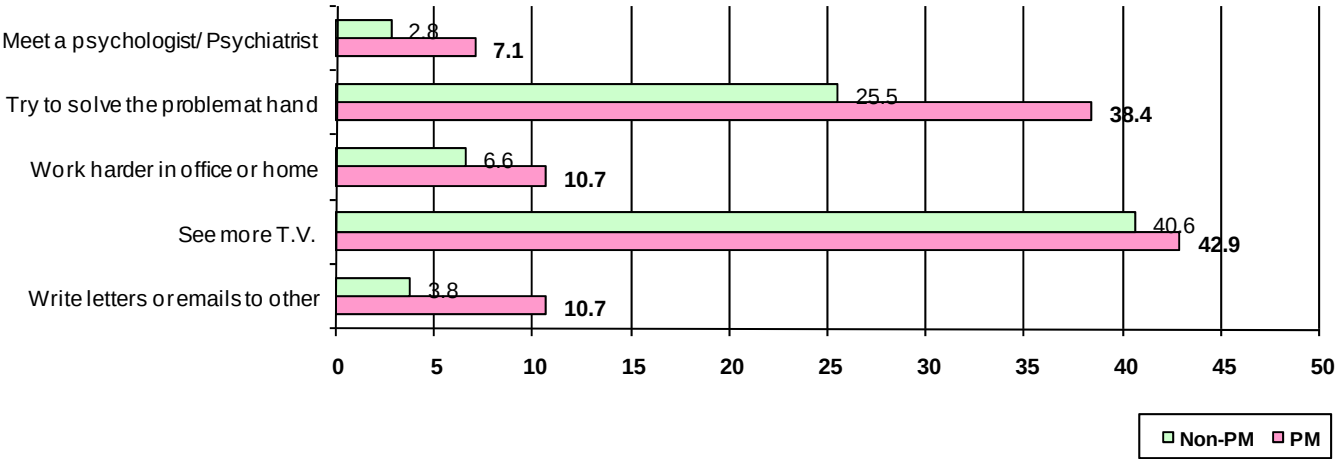

Fig No:15

Figure below shows the behaviors that the non-PM group engaged in significantly more often than PM group.

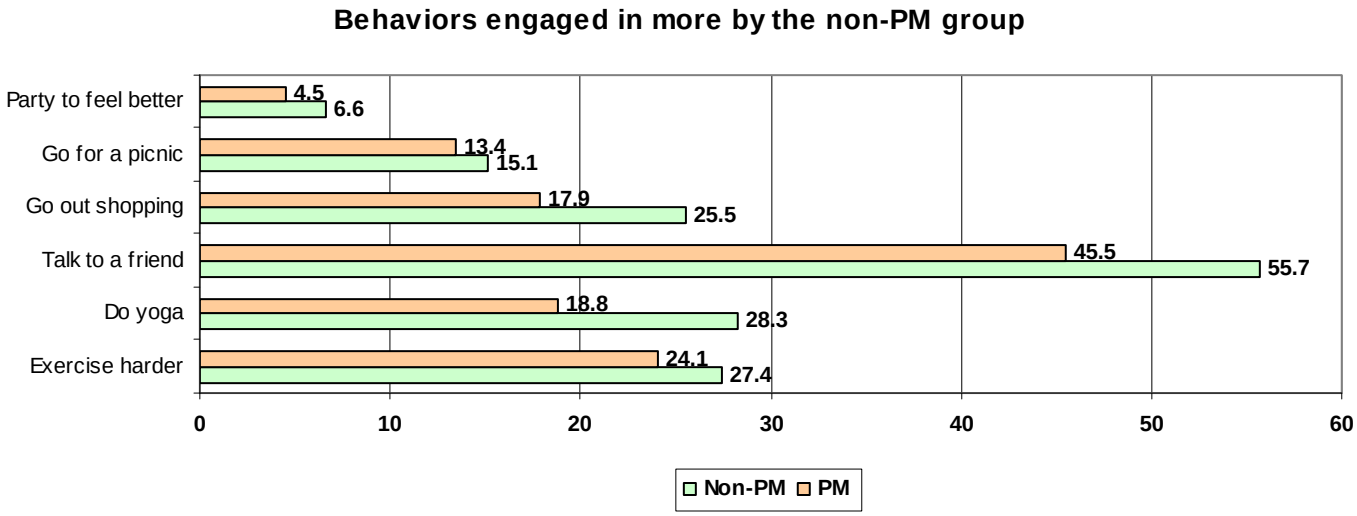

Fig No:16

There was no significant difference between the PM and Non PM groups on two behaviors, 'discuss the actual problem, if any, with others' (13.4 vs. 13.2%) and 'visit a doctor' (48.2 vs. 48.1%)

Some conclusions can be drawn from these findings. The PM group is more likely to seek support from family, and less likely to seek out to friends. This could be because the fear of stigmatization if their psychiatric status is known to others prompts them to seek the confidentiality of close family members. This is also reflected in their higher likelihood to prefer solitary activities like walks.

They are more likely to engage in unhealthy and maladaptive behaviors like drinking alcohol, smoking, or taking mood elevating drugs. They are more likely to repose confidence in remedies and explanations relying on faith and supernatural influences. Whether these patterns of behavior are *primary* (causally related) to their psychiatric disorders, or *secondary* to them, needs further elucidation.

It is understandable that PM group, consisting of persons with psychiatric problems, is more likely to try to solve their problems, and to meet a psychiatrist or psychologist more often. Visiting a general doctor, on the other hand, something all people have to do quite often. Hence, the frequency of doctor visits was high (almost 50%), but comparable, in both groups.

The behaviours that the non-PM group engage in more often fall into two clusters. Yoga and exercise constitute *health-promoting* activities, and talking to a friend, shopping, picnics and parties are *socializing* activities. This confirms what is well known, that freedom from mental illness is associated with healthy and socialized lifestyles.

Part B) : Help Seeking Behavior (as highlighted by the 9 FGDs).

HELP SEEKING BEHAVIORS

People in the various groups tried out several coping behaviors themselves to help themselves to deal with common, emotional difficulties like daily hassles, coping with authority figures, multiple tasks and financial problems.

A. HELP SEEKING BEHAVIOUR VIA SELF HELP

Whenever they felt helpless or depressed they sought to use these coping behaviors

Positive Coping:

1. Share problems with some family member or colleague/ friend.
2. Pray or meditate
3. try to be satisfied in all situations
4. Don't blame anyone
5. Accept circumstances
6. Focus on other people's good qualities
7. help others, them God will help you
8. have a routine even in old age
9. Join clubs or some association to decrease stress.
10. try to be busy all the time
11. try yoga
12. Spend time with grandchildren, share wisdom

Faulty Coping:

1. Anger, including physical fights
2. Withdrawal, alienation
3. Altered communication like being passive, defensive or blaming.
4. Inability to share due to lack of trust.
5. Fatalism
6. see excessive TV or use computer to escape / or as a habit

None of the participants mentioned using alcohol or other drugs to relieve stress, probably due to the social inappropriateness of the situation.

Some of the younger members admitted to go shopping to actually release stress rather than enjoy the shopping. They reported that since true happiness is something beyond them due to the need to struggle 12- 15 hours daily, they would rather change their car models and mobiles to feel happy.

HELP SEEKING BEHAVIOUR INVOLVING OTHER AGENCIES

With regard to approaching doctors or other professionals, participants have tried various places and have various opinions.

MEDICAL PROFESSIONAL

General Practitioners, Cardiologist, Orthopedicians, Gynecologists, and peadiatricians are the first contact for the most people having mental health concerns. They feel comfortable visiting/ and expressing their concerns with a doctor. Many doctors present in FGDs repored observing issues esp. anxiety, palpitation etc and wanting to make a further referral but unawareness of existing services. They also reported that since the system of the 'family physician' is getting outdated, with more and more specialists taking over, the family has lost not only a good doctor who knew everything about the family history; but also a good counselor.

THE MENTAL HEALTH PROFESSIONAL:

Most people are apprehensive of approaching a psychiatrist or a psychologist for various reasons.

- The stigma attached to mental illness
- The expensive treatment
- Probability of several year of medication being prescribed
- Fear that they may be quacks and not efficient professionals
- Feeling self- conscious in the presence of other patients, some of whom may be seriously mentally ill.
- Feeling apprehensive about how 'talking' treatments will help them get better (in case of a psychologist)
- Several participants said that they felt a need to approach a mental health professional but a lack of trust coupled with non-availability of professionals in nearby locations discourages them.
- The poor state of government hospitals, the lack of waiting areas and long queues especially since treatment would be long and repetitive visits would be required.
- Some people with mentally ill wards reported banned medication being prescribed to them.
- Amongst the people (at least 1 or 2 in each group) who have visited a mental health professional for themselves or someone else, a higher trust and a better understanding was seen.
- For childhood mental health issues, people seem to be more open in approaching a child guidance center or a counselor. People report lesser stigma. However adolescent children themselves refuse to approach a counselor for help.

Overall a lack of trust and confusion about mode of treatment seem to be factors dissuading people from approaching mental health professionals.

RELIGIOUS LEADERS

People reported that *tantriks* and astrologers are approached regularly. Several families have family *pandits* and gurus who act as religious healers as well as counsel the families. One such participant, himself a *pandit*, claimed 'treating' several phobias and fears with family counselling and prayers to certain planets. Amongst other issues are several couples who will normally go to this set of healers for help. Not only the uneducated but also the educated middle class individuals approach them.

ALTERNATIVE MEDICINE

Ayurveda and yoga were frequently used methods to treat mental health concerns.

HELP SEEKING BEHAVIOUR OF WOMEN

Help seeking among women revolves around sharing within family, especially with grown up children or visiting the market or yoga and exercising. They report being comfortable sharing with a teenaged son/ daughter. They feel unable to trust other women in the family. They do not expect any support or physical effort from their spouses and also report that support from husband is minimal. Educated and / or working women do share the decision making to approach a doctor or mental health professional, but others do not enjoy this power. The husband decides whether to take them to a Doctor, whether to admit them or not. Often the woman is sent back to her parents place if she has a mental illness.

SECTION V: MENTAL HEALTH AWARENESS AND STIGMA

In this study we highlight the mental health awareness, available resources and stigma associated with mental illness both by quantitative analysis as well as by FGDs findings.

Part A) In the Questionnaire, we evaluated the awareness about availability of mental health facilities via checklist.

Only 38 of the 2381 respondents (1.6%) said that they were aware of any agency where mental health facilities were available. Of these 38, 22 were from the PM group, and 16 from the non-PM group. In other words, within the PM group, 12.2% were aware of these facilities, while only 0.7% of the non-PM group had this awareness. Of these 38 subjects, 44.2% mentioned government hospitals, especially Guru Tegh Bahadur Hospital (21.2%) and AIIMS (5.3%). 23.5% mentioned private nursing homes, and 7.8% named their local practitioners.

Finally, the respondents were asked whether they had visited any mental health professional in the last one year. Only 17 of the 2381 respondents (0.7%) replied in the affirmative. Only 6 of the 180 persons with psychiatric morbidity (3.3%) said yes. This means that less than 5% of persons with psychiatric problems received proper treatment for their disorders.

MENTAL HEALTH AWARENESS AND STIGMA

Participants reported that very often, people suppressed their 'low' feeling or '*ghabrahat*' till the time they could no longer take it. Only then they tend to express it to someone, generally a Doctor. Doctors in the groups reported that very often stress related problems or even more serious mental disorders presented to them as aches and pains or other gastrointestinal problems. People are not ready to talk about stress or mental health, yet its this what came through in the discussion. Some main points were:

STIGMA ABOUT MENTAL ILLNESS

Stigma is one of the major concerns due to which people do not even talk or seek information on mental illness.

Media is insensitive and uses the concept of mental illness without any censors. Sometimes the topic is not well researched.

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"Mental illness can not be cured, medicines continue for a life time in all mental illnesses, only 'weak' people become ill" and "mental illness can be due to the problems in one's destiny" are some of the misconceptions voiced by the groups.

That mentally ill individuals behaves awkwardly and hence it's scary and difficult to interact with him"

" Once a person has a mental illness, he has no insight"

"People sympathize with the mentally ill, but don't want to be with them"

Predominantly stigma affects the most when marriage and job are sought.
Mental illness, depression *pagalpan* are all used interchangeably due to lack of knowledge.

Some of the participants reported that they know several people seeking help who were also functional and 'normal' otherwise. A slight change in attitude seems to be in place vis-à-vis depression in that it can be treated, it is not so uncommon etc."

WOMEN & STIGMA

Women very often manifest physical complaints to express their stress. With women, other problems like lack of decision making power and also a lack of education in some cases keeps them ignorant and unaware of mental health issues.

CHILDREN & STIGMA

Children are also aware of the stigma surrounding the 'school counselors' and avoid talking about problems.

DISPELLING MYTHS AND INFORMATION DISSEMINATION

After understanding the group's reactions and reports, in FGDs, the facilitator spoke about mental health using the following key points:

- ✓ Mental health was defined as a state of well being, free from illness and having adequate confidence in coping with stress.
- ✓ It was emphasized that all of us have mental health issues at some point in time. There are phase of low mood, anxiety due to circumstances.
- ✓ However it was explained that sometimes these phases stretch over weeks and months and are severe enough to warrant help. Thus the duration, frequency and severity of 'symptoms' decides the need and type of treatment.
- ✓ The major psychological and psychiatric disorders were enlisted. Depressive disorder, anxiety disorders- panic disorders, phobias, obsessive compulsive disorder, and psychotic disorders like schizophrenia and bipolar disorder were described in simple, clear manner. It was seen that some of the members reported some of their relatives and friends having gone through some of these disorders.
- ✓ Treatment was explained as a combination of psychiatric, psychological and family inputs. Medication, it was explained would be required and would be the main treatment of psychotic disorders and could continue for several years or a lifetime. However in neurotic or other illness this may not be true.

- ✓ Psychological treatments were described as of techniques and therapies used to treat the negative and faulty thought processes as well as behaviors of people. Counseling was done to family members to psycho educate them and help them maintain the improvement.
- ✓ It was emphasized that the community's empathy and positive attitude towards the treatment contributes in enhancing the patient's well being and confidence in coping.
- ✓ It was also shared that unfortunately there was a dearth of mental health professionals with the number of psychiatrists being 4000 and the number of qualified psychologists being 400 in the country. It was also emphasized by the facilitator that this burden of prevention and treatment at least at the primary levels needs to be shared by doctors from all specialties, health care workers, teachers, faith- healers and the community at large. Early detection and screening, as well as referral to the right professional, is a task that if well- informed, all of these individuals can easily carry out.

Vox Populi

Participants had several suggestions to improve the state of mental health in Delhi. First of all they enlisted the kind of behaviors people should pursue to buffer stress:
Revert back to the traditional Indian value system with its family values, organized routine and spiritual back up.

- Help others, this provides for better mental strength for yourself and a stronger support system.
- Keep busy and actively solve problems. Do not avoid.
- Focus on social well being in your old age
- Trust your spouse and family
- Do not give importance to people's negativity, look at the positives
- Elders should be relaxed and non- pressuring as children are already pressured and stressed.
- Parents should force children to play in fresh air daily
- Use of TV and computer should be decreased.

The citizens of Delhi also gave suggestions to the policy makers to improve the state of mental health of all residents:

- There should be mass awareness campaigns about mental health
- Psychological/ mental health should also be assessed in general health check ups
- All kinds of measures should be taken to decrease stigma
- Hospitals should be made patient friendly
- Doctors should be screened so that they do not provide banned medication.
- There should be an emphasis on creating a safer environment for women both in their own homes and outside. Overall status of women should be improved as dowry, poor treatment to women at all levels increases stress.
- There should be more open places for children to play

- Doctors should be made aware of various mental health problems and they should promote mental well being in all their patients.

- Religion and religious teaching should incorporate aspects of mental wellbeing and awareness of various problems as well as encouragement to teach out to the right professional.

- More workshops on self- awareness are needed to remain mentally healthy. " *swasthya*" comes from "self"

- Delhi must take the lead in creating this awareness and as the capital of the country we must be healthier. Already people in Delhi are now more health conscious, exercise diet and do more yoga than earlier.

- Most importantly, the government should take active measures to disseminate information about policies and initiatives spread awareness about benefits/facilities available for people with disability and mental illness.

Executive Summary

A survey study titled "State of mental health in Delhi: Prevalence of psychiatric morbidity, subjective well being, and patterns of help-seeking behavior among the general population of Delhi" was undertaken by Manas Foundation with the support of Planning Commission in the year 2008. A sample of 2381 respondents was drawn from the seventy constituencies in Delhi. The profile of this population showed an almost equal sex distribution, with 48.6% women and 51.4% men. The average age of the sample was 36.3 years.

The focus of the study was to understand the prevalence of psychiatric morbidity and psychological distress amongst the general population in Delhi. Subjective wellbeing, which is a feeling of general life satisfaction, in the absence of depression and anxiety, was another variable of the research. The study also aimed to understand people's perceptions about mental illness, the myths and stigma prevalent amongst them. The various help seeking behaviours people resort to in case of stress related issues, or mental illness, had also been an important objective of the study. Both quantitative and qualitative data analysis was done.

SALIENT FINDINGS

The prevalence of psychiatric morbidity was found to be 7.6% amongst the population of Delhi. This high prevalence imposes a huge burden on the health of civil society, and needs targeted policy initiatives and interventions.

With regards to subjective wellbeing, People in Delhi report high level of distress and poor subjective wellbeing both in quantitative analysis and FGDs. No significant differences were found amongst various groups, ie with regards to age, gender, martial status, educational status, income status (overall mean 21.43 on SUBI, median 18). Higher the score toe poor is the well being. In the FGD's, the population of Delhi esp. women reported that they were highly stressed out. Most of the significant stressors were crowded roads, long distances, long hours away from family, and hence inability to relax and cope with problems. The general attitude of people to disregard stress and move onto complete tasks and work or avoid issues seemed only to make this problem graver. Working women reported a continuously busy day all the time, leaving them little time to look after their relaxation and health. Overall the people in the study reported good material wellbeing and financial status, but reported poor overall life satisfaction and high stress levels.

Help seeking behaviors were found to be conventional and limited. While the psychiatric morbidity group reported more family support and belief in astrologers and faith healers, the group without psychiatric morbidity reported more health promoting behaviours like yoga, exercise as well as supportive interpersonal relationships. Both positive and faulty coping were reported by the people.

Only 1.6% of the total samples were aware about availability of mental health facilities. This abysmally low figure gets even starker when we find that even amongst persons with psychiatric morbidity, only 12.2% were aware of such facilities.

A need to approach a professional for help was perceived by several people, but only 0.7% ever visited any mental health professionals in the last one year. Two factors which contributed significantly were lack of knowledge about where to go, and a strong stigma about being perceived negatively by others as a mentally ill person. General parishioners were the first line of consultation for most people with mental health issues. High stigma was reported regarding visiting a mental heath professional. People who had physical disability or mental handicap within the family were more open as well as aware of mental health facility, than families of people with mental illness.

Factors like long and expensive treatment, possible overuse of medication, inability to distinguish between various kinds of mental health professionals further complicated the help seeking attitudes of people.

To summarize, the study indicates that the population of Delhi has high prevalence of psychiatric morbidity, poor subjective wellbeing and unacceptably low levels of awareness about the mental health services and issues. This has resulted in, negligible numbers of persons with mental illness visiting mental health professionals.

Recommendations and Future Directions

The following recommendations emerged from the study:

Most people find mental health services expensive and hence cumbersome. Most treatments are indeed long-term spanning several months to several years. Also, most people with Mental illness and their families are unfortunately unaware of the benefits & facilities already spelled out for them. It is necessary to do awareness campaign and make them aware so that they can be adequately utilized.

Dissemination of correct information on all kinds of mental illnesses and stress related mental health issues needs to be done. This should be done in print as well as electronic media in simple and local languages.

Counseling services need to be placed in central areas, to make them easily available and to destigmatise mental illness.

OPD services, both psychiatric and psychological, should be provided in all dispensaries and community centers regularly.

An attempt should be made to plug in the mental health component as a part of general health checkups.

A systematic training of medical practitioners and other paramedical staff in specific psychiatric and psychological disorders need to be conducted to sensitize them as well as to aid in screening for mental illnesses.

Due to the dearth of mental health professionals, training in psychological skills for selected lay people or staff of NGO's working in the social service sectors can be done. This will aid in creating awareness and primary prevention.

Schools, RWAs, and the Corporate Sector can be used as smaller communities where regular workshops and support groups are held. Primary prevention should aim at and stress management should be targeted. The overall health checkup should include screening for mental illnesses. In due course, screening of other Mental illnesses should be undertaken.

Another level at which mental health professionals, policy makers and the people need to get together is for the rights of people with mental illness.

It is recommended that the policy makers allot adequate funding for the mental health needs and convey this information to the general population.

As some of the respondents in the FGDs told the researchers,

"Delhi must take the lead in becoming mentally healthier, as it has in becoming physically more diet conscious and in regularly exercising."

This is the juncture where the people of Delhi are feeling at the edge and stressed out. They are at the brink of seeking for help but are confused and in the dark. Left alone, this "feeling" may translate into something more serious, causing loss to the emotional and psychological wellbeing of people as well as eat into the economic resources of the city. If prevented at this point, we may ensure better wellbeing and a more enlightened and empowered people.

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Appendix A – Questionnaires

General Health Questionnaires (GHQ): The GHQ, developed by Goldberg (1972) is a well-used standardized questionnaire, for most mental health epidemiological researches. A 12-item brief scale, it can be easily administered and scored GHQ scores give clear indicators of psychological distress and disturbance. The higher the score, the higher the psychological disturbance. When Scaled scores are used, a cut-off score of 3 and above is indicative of psychiatric morbidity. The GHQ is a measure of the burden of psychological distress and of possible psychiatric disorder. The impact in terms of dysfunction and impaired productivity and well being imposed by diverse problems like situational stress, anxiety and depressive disorders is captured by this instrument

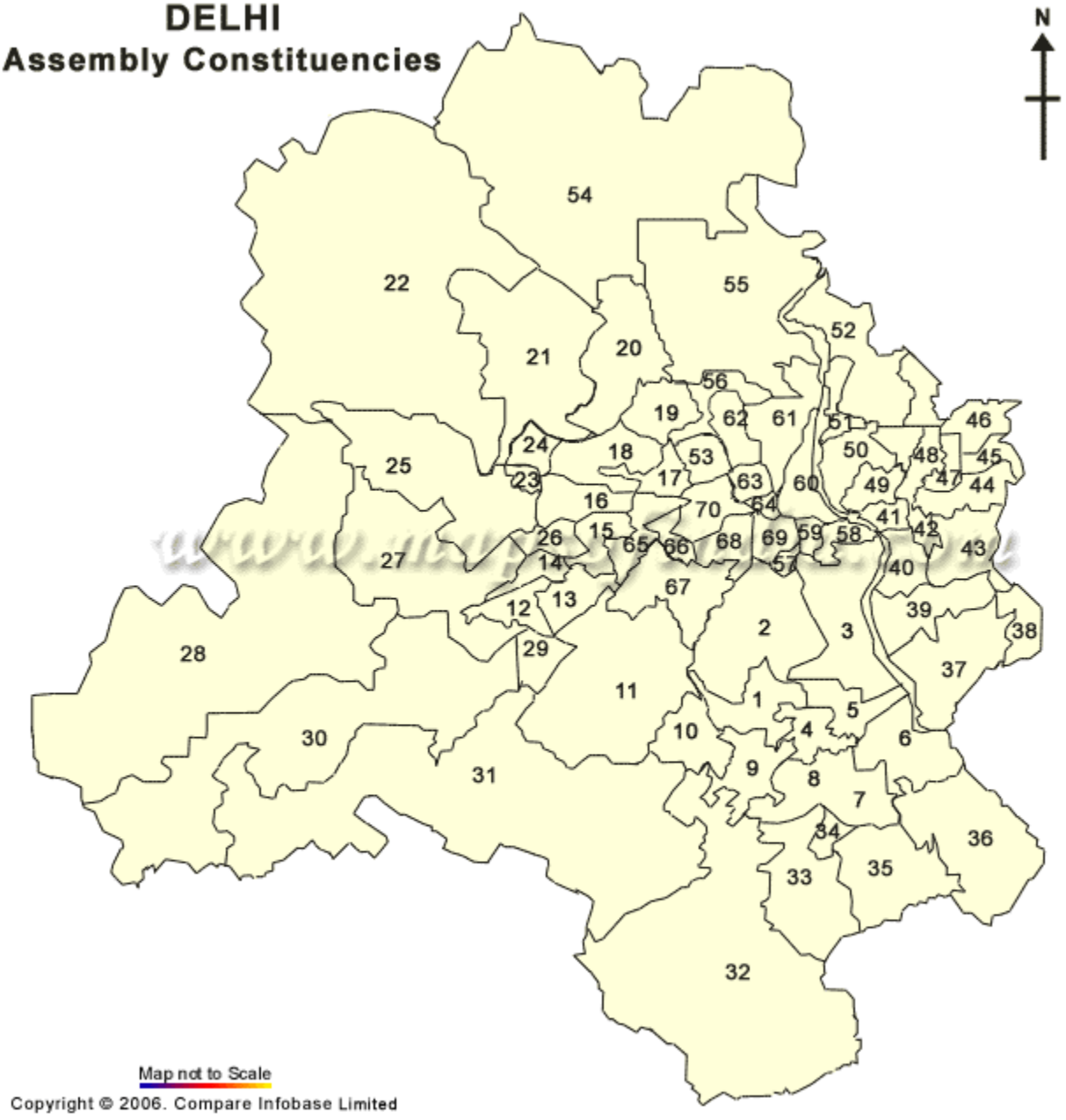
2. ***Subjective wellbeing Questionnaire (SUBI):*** The SUBI developed by Nagpal & Sell (1985) for the World Health Organisation is a standardized Indian questionnaire. Subjective Well Being is a composite measure of independent feelings about a variety of life concerns in addition to an overall feeling about life in positive and negative terms. It has a shorter version of 9 items, developed by Indian Social Studies Trust (ISST) (2003) which taps 9 dimensions such as positive wellbeing, confidence in coping. Mental health is not only the absence of mental illness. It also encompasses positive attributes like resilience, satisfaction, and quality of life. These attributes are measured by the SUBI.

Thus, the GHQ and SUBI together provide a global perspective on the various dimensions of mental health.

3. ***Help-seeking Behaviour Questionnaire (self - developed):*** an attempt has been made to develop a brief questionnaire to assess the type of approaches people use when they face a mental health problem. A thorough research of existing questionnaires and studies in Community Mental Health and local practices has been made before developing this short questionnaire. The questionnaire contains 10-12 items in a Yes/No format. Space has been provided to fill in any other information/ behaviour not included in the questionnaire. A small pilot study assessing 10% of the total sample was conducted to establish the validity of the questionnaire. Items include questions pertaining to commonly used practices of consulting a faith healer, medical practitioner, local leaders, influential family members, priest/pundits, or astrologers.

4. ***Sociodemographic data face sheet:*** was included to collect data about age, gender, Socio-economic status, educational level, marital status, occupation and income, type of family and number of children.

Appendix B- Delhi Political Map



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