

# Profile of Women with Mental Illness Admitted in Shelter Care Homes; A Co-relational Description of Changing Sociocultural Scenario in India

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## Abstract

**Background:** The prevalent explanations of gender and mental illness in the Indian social structure often highlighted in terms of traditions and gender-colored norms which is confirmed with the patriarchal framework. The combination of women and diagnosis of mental illness disturbs the prescribed gender expectations which accelerate the family abandonment, and many women lead their life in shelter care homes after psychiatric hospitalization. The aim of the study is to assess the sociodemographic characteristics of the residents admitted in shelter care homes and understand the co-relational aspects of changing sociocultural scenario. **Subjects and Methods:** Recruited 50 women residents living in 14 centers both the governmental and nongovernmental shelter care homes in Bengaluru, Karnataka. Utilized sociodemographic datasheet to assess the sociodemographic variables and retrospective file review to elicit commonalities among the sample. **Results:** The current study reveals that majority (74%) belongs to the nuclear family, lived in a rented house before institutionalization (46%). The reason for stay in shelter care home reported to be family abandonment and rejection (72%) and majority of the residents experiencing chronic homelessness (92%) are unmarried/separated (82%) and majority revealed none of the family members ever visited them in shelter care homes (66%). **Conclusion:** It is imperative to understand the connection between sociodemographic details of the women admitted in shelter care homes and the rapid changes occurring in the sociocultural structure for comprehensive understanding of mental illness-homelessness-institutionalization nexus.

**Keywords:** Gender, homelessness, mental illness, shelter care homes

## INTRODUCTION

In India like developing country, mental healthcare delivery and infrastructure-related aspects gained more attention recently. The continuity of care and psychiatric rehabilitation aspects seems to be a subject matter for discussion in both governmental and nongovernmental platforms. In Indian social climate, considering the mental health service users, especially women section viewed to be in a vulnerable stand in relation to the family's involvement in aftercare activities. The mental health of women is strongly associated with their status in society, and it reports to be benefits from the equality and suffers from discrimination.<sup>[1]</sup> The prevalence of stigma in relation to mental illness is well documented in the Indian context.<sup>[2,3]</sup> Previous researches have portrayed that there are gender differences in familial engagement in mental health treatment and rehabilitation-related aspects.<sup>[4]</sup> A growing body of evidence suggests that there are multiple reasons behind

the familial abandonment such as poverty, stigma, illiteracy, and the death of primary caregivers.<sup>[4,5]</sup> Broadly, the family abandonment scenario classified as helpless abandonment, careless abandonment, and willful abandonment based on the underline reasons behind the family rejection.<sup>[6]</sup> After long-term psychiatric hospitalization, many women were admitted to shelter care homes in view of various psychosocial factors.<sup>[7]</sup> The aim of this study was to assess the sociodemographic characteristics of women with mental illness admitted to shelter care homes. An additional coverage also given to the homelessness-related factors.

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## SUBJECTS AND METHODS

The researcher identified and selected shelter care homes on the basis of availability of the women residents who were also service users of the tertiary care hospital and accommodated in the shelter homes due to various psychosocial circumstances. Of 20 shelter care homes visited, 14 found to be the shelter for the women as per the inclusion criteria. The sample consists of 50 women residents staying in 14 shelter care homes in Bengaluru, Karnataka. Women aged 18–60; those who were capable of giving written informed consent were included in the study. The samples were selected by utilizing nonrandom judgmental sampling, and the sample size was limited based on the availability of the residents during the period of data collection. The residents who are having intellectual developmental disorder/other neurological conditions were excluded from the current study. The residents were interviewed using a sociodemographic datasheet which consists of personal, familial, clinical, and current stay related details. The datasheet was content validated by six mental health professionals (1 psychiatrist, 1 clinical psychologist, and 4 psychiatric social workers). Two sets of data were collected. Primary data were collected from women residing in shelter care homes/secondary data were collected from the case files of the women using file review performa. The primary data were analyzed using descriptive statistics. This study received ethical approval from the Institute Ethical Committee Behavioral Sciences Division of the NIMHANS (NO.NIMH/DO/IEC (BEH. sc. DIV/2016).

## RESULTS

The results section divided into two parts: primary data of personal, familial and clinical details, and retrospective file review findings.

### Individual and familial aspects

As shown in Table 1, it reflects that many of the participants remained unmarried or separated from the marital relationship (82%), more than half of the participants belong to the Hindu religion (64%). A considerable number of women (38%) appear to be educated up to the level of above high school, and 60% were unemployed before admission in shelter homes. Regarding domicile majority reported to be resided in the rural area in their early stages of life (48%). Nearly 98% of participants reported that they have family and 64% reported families are aware about their current stay. In this sample, 88% of respondents have siblings and 50% of women's families stay in their own homes. 66% of participants reported that their family never visited them after the admission at shelter care homes. Majority of the respondents (66%) leading their life inside governmental or government aided shelter care homes which caters their basic needs and necessities. The mean age of rejection experienced from the family was  $37 \pm 10.5$ . The main reason behind admission in shelter care homes noted to be family abandonment and poor social support (72%). Among these samples, 84% of women

**Table 1: Personal, familial, and clinical details**

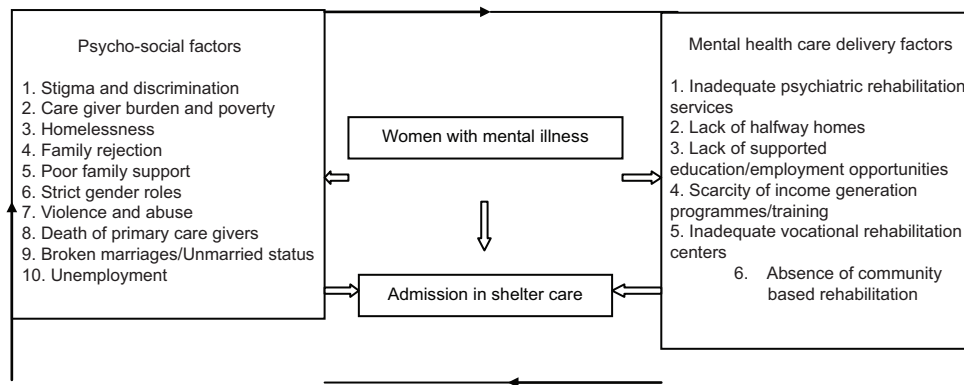
| Age related aspects  | mean±SD       |
|--|---------------|
| Mean age (years), mean±SD                                      |               |
| Current age  | 42.7±10       |
| Age of onset of psychiatric illness                            | 27.5±7        |
| Age of homelessness/family abandonment                         | 37±10.5       |
| Variable   | Frequency (%) |
| Marital status   |               |
| Unmarried/separated  | 41 (82)       |
| Religion   |               |
| Hindu  | 32 (64)       |
| Diagnosis  |               |
| Nonaffective disorders   | 39 (78)       |
| Domicile   |               |
| Rural  | 24 (48)       |
| Education  |               |
| Greater than high school                                       | 19 (38)       |
| Employment before  |               |
| Unemployed   | 30 (60)       |
| Type of homelessness   |               |
| Chronic  | 46 (92)       |
| Place of stay before   |               |
| Rented house   | 23 (46)       |
| Type of family   |               |
| Nuclear family   | 37 (74)       |
| Reason for stay in shelter care                                |               |
| Family abandonment and poor support                            | 36 (72)       |
| Type of shelter care homes                                     |               |
| Governmental/government aided homes                            | 33 (66)       |
| Caregiver before   |               |
| Parents  | 31 (62)       |
| Duration of homelessness (years)                               |               |
| <5   | 28 (56)       |
| Total number of psychiatric hospitalization                    |               |
| Two time   | 22 (44)       |
| Information about family                                       |               |
| Aware  | 49 (98)       |
| Families' awareness about residents' stay                      | 32 (64)       |
| Frequency of family member visit to shelter care               |               |
| Never visited  | 33 (66)       |
| Nature of house of family                                      |               |
| Own house  | 25 (50)       |
| Siblings   |               |
| Yes  | 44 (88)       |
| Duration of stay in current shelter care home (years), mean±SD | 3±3           |
| Number of hospitalization, mean±SD                             | 2±1           |
| Total number of institutionalization, mean±SD                  | 1.5±1         |
| Lived years outside family (years), mean±SD                    | 5.7±5         |

SD: Standard deviation

experienced chronic homelessness as a by-product of having the diagnosis of mental illness.

### Clinical aspects

The participants having the diagnosis of nonaffective disorders (78%) seemed to be prominent. The mean age of onset of psychiatric

**Table 2: Factors leading for admission in shelter care homes**

illness was  $27.6 \pm 7$  and majority reported two times psychiatric hospitalization (44%).

### Retrospective file review findings

The file review mainly aimed at understanding commonalities across the lives of these women with mental illness admitted in shelter care homes for further care. The available medical record file of the current samples reviewed using file review performa in the medical record department. The important findings are given below:

#### Commonality in symptom profile

Suicidal ideas, disinhibited behavior, wandering behavior, poor self-care, and psychotic symptoms were commonly documented in the file.

#### Commonality in psychosocial aspects

Drug compliance issues, presence of stigma, poor social support, and interpersonal relationship issues.

#### Presence of traumatic life events

Majority of women had undergone multiple traumatic life events in the form of death or suicide of significant others, history of abuse, traumatic experiences in school, marital discord due to the extramarital affair of husband, loss due to death of primary care provider (parents), and financial loss.

#### Commonality in interventions

Majority of these women were admitted in the closed ward for psychiatric care in view of the absence of caregiver, financial issues, aged caregiver, and escaping tendency from the open ward. The psychosocial interventions offered by the multidisciplinary team members include psychosocial assessment, facilitating in availing of hospital benefits, disability certification, advocacy, and networking efforts with various organizations such as legal department, Police stations, tracing the family members, and home visits whenever required.

## DISCUSSION

This study highlights the sociodemographic profile of those women who forced to be in an institutional setup due to

various structural and functional inadequacies of mental health care delivery systems, lack of familial engagement, and rehabilitation aspects [Table 2].<sup>[8]</sup> In women-specific scenarios, how patriarchy involves in relation to mental health and its vulnerable location is documented in the literature.<sup>[9]</sup> Women who have a mental illness appeared to be at a particular disadvantage in India. There are clear factors that significantly affect the occurrence, manifestations, treatment, and outcome of mental disorders in women of India, like patriarchy, marriage as a must one, preference for the male child, and dowry.<sup>[10]</sup> The current study demonstrates that the sociodemographic profile of women diagnosed with mental illness staying outside the family context clearly has a connection with the postmodern influence and changing social structure in the Indian scenario.

### Shift in familial landscape and individual orientation

Historically, the joint family system is regarded as one of the unique features of Indian society, and the collectivist orientation of family relationships was well-known in this context. The changing trend of the disintegration of the joint family system and the very existence of nuclear families reflects its effects in the current study. Majority of participants belongs to nuclear family (76%). Eventhough many of them have siblings at home (88%) they ended up living in shelter carehomes.

### Handing over responsibility from family to state

The number of residents staying in government/ government-supported shelter care homes (66%) reflects another fact that the handing over responsibility from family to the state becomes more visible in this sample. Irrespective of having family, many of the women ended up in government shelter care homes, mainly due to the zero costs involved in the aftercare aspects. The overcrowded government facilities also observed to be one of the growing concerns in the changing social scenario.

### Convergence of rural-urban boundaries: Industrialization and urbanization

India, the land of villages, heading toward the urbanization and the society is in a transitional stage of accommodating

differences. Many of the respondents reported that they lived their early stages of life in the rural area (48%), and many lived in rented house (46%) before admission to the shelter care homes. This phenomenon should understand from the heavy load of the density of the population in the urban areas and how it compromises the housing needs of the population which gradually leads to homelessness in this particular population. The small size urban-friendly family seems to be prevalent in all most all parts of the country, where urbanization is taking part [Table 2].<sup>[11]</sup>

### Strong existing features: Stigma and labeling

The marriage and family life seems to be a difficult target for women with mental illness; the current study highlights that the majority of participants fall into the category of divorced/unmarried. Another study conducted in India already mentioned the hardships encountered by the separated/divorced women with mental illness.<sup>[12]</sup> One courts-based study also highlighted that the judgment related to annulment and divorce in the background of mental illness, 85% of the cases were filed by husbands, who alleged that their spouse was mentally ill, in which cases reaching at high court 95% were filled by the male petitioners.<sup>[13]</sup>

### Employment and educational opportunities

Considering from social inclusion aspects, employment, and educational opportunities are integral in initiating the community re-integration efforts. Irrespective of having basic educational qualifications, the majority of the women admitted in shelter care homes seem to be unemployed (60%) throughout their life.

### Stuck in institutionalization

In the current global scenario, psychiatric rehabilitation focuses on the recovery-oriented services, supported employment, and community-based rehabilitation and reintegration efforts. In the unsupportive family background, institutionalization appears to be quite rampant in the aftercare options. The lack of well-planned community rehabilitation models and gender-sensitive policy level initiatives seem to be significantly lacking in the Indian context. Currently, in India, the women with mental illness experiencing familial rejection does not have any other option than staying in a long-term shelter care home to cater their basic needs. The innovative psychiatric rehabilitation services such as supported housing, supported education, and employment is essential for meeting the needs of this population.<sup>[14]</sup>

## CONCLUSION

Viewing from the changing sociocultural climate, it is imperative to introduce innovative psychiatric rehabilitation services emphasizing on the facilitation of recovery than

limiting the alternative options available for this specific group of women. Institutionalization segregates them from mainstream society, and they have to lead their lives in seclusion. By utilizing progressive sections mentioned in the New Mental Health Care Act 2017 and rights of persons with disabilities act, it is essential to create a supportive environment which ensures sustainable support to this specific population. The time, resources, and professional ethics involved in mental healthcare should be carried out toward the stigma reduction, community-based interventions, and awareness creation in this regard.

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### Conflicts of interest

There are no conflicts of interest.

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