INTERNATIONAL JOURNAL OF RESEARCH IN COMMERCE, IT & MANAGEMENT

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REVIEW OF LITERATURE

NEED/IMPORTANCE OF THE STUDY

STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESIS (ES)

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

LIMITATIONS

SCOPE FOR FURTHER RESEARCH

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WOMEN's MENTAL HEALTH IN INDIA: ISSUES AND CHALLENGES

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ABSTRACT

Review was done to assess the burden of mental disorders and to study the various issues and challenges of women at community level. We searched the electronic databases for studies related to prevalence of various psychiatric morbidities and associated factors at community level. World Health Organization estimated that mental and behavioral disorders account for about 12 percent of the global burden of diseases. In India the burden of mental and behavioral disorders ranged from 9.5 to 102 per 1000 population. And women are having more than 64 percent. As per World Health Organization (WHO) estimates, depression is expected to be the second largest contributor to disease burden by 2020, and with one in every three women worldwide being afflicted by common mental disorders including depression, the mental health of women is a serious issue indeed. Burden of mental disorders seen by the world is only a tip of iceberg. Various studies had shown that the prevalence of mental disorders were high in females, elderly, disaster survivors, industrial workers, children, adolescent and those having chronic medical conditions. There is need to have better living conditions, political commitment, primary health care and women empowerment. Considering the gravity of the matter, urgent remedial measures such as understanding the underlying causes of psychological distress among women, adopting a gender-sensitive approach, working towards women's empowerment and formulating women-friendly health policies could work wonders for the mental health of Indian women. The Paper shows the detailed study about the women's mental health in India: Issues and Challenges.

KEYWORDS
common mental disorder, disorder, distress, health policies.

INTRODUCTION

Both Women and men are different not only in their obvious physical attributes, but also in their psychological makeup. There are actual differences in the way women's and men's brains are structured and "wired" and in the way they process information and react to events and stimuli. Women and men differ in the way they communicate, deal in relationships, express their feelings, and react to stress. There are psychological theories that present a gender sensitive viewpoint called as alpha bias, and there are others that are gender neutral representing. Men and women are different and opposite, and differences between men and women are ignored.

Roles of gender have been culturally prescribed through the prehistoric cultures to the more civilized societies. In hunter gatherer societies, women were generally the gatherers of plant foods, small animal foods, fish, and learned to use dairy products while men hunted meat from large animals. In more recent history, the gender roles of women have changed greatly. Traditionally, middle-class women are typically involved in domestic tasks emphasizing child care. For poorer women, economic necessity compels them to seek employment outside the home. The occupations that are available to them are; however, lower in pay than those available to men leading to exploitation.

Gradually, there has been a change in the availability of employment to more respectable office jobs where more education is demanded. Thus, although, larger sections of women from all socioeconomic classes are employed outside the home; this neither relieves them from their domestic duties nor does this change their social position significantly. For centuries, the differences between men and women have been socially defined and distorted through a lens of sexism in which men assumed superiority over women and maintained it through domination. This has led to underestimating the role a woman plays in the dyad of human existence.

It is necessary to understand and accept that women and men differ in biological attributes, needs, and vulnerabilities.

A. BRIEF PROFILE OF PSYCHIATRIC DISORDER AND PSYCHOSOCIAL DISTRESS

PSYCHIATRIC DISORDERS

Analysis of empirical studies of mental disorders reveals a consistency across diverse societies and social contexts: symptoms of depression and anxiety as well as unspecified psychiatric disorder and psychological distress are more prevalent among women. The disability-adjusted life years' data recently tabulated by the World Bank reflect these differences. (5) Depressive disorders account for close to 30 percent of the disability from neuropsychiatric disorders among women, but only 12.6 percent of that among men. Conversely, alcohol and drug dependence accounts for 31 percent of neuropsychiatric disability among men, but accounts for only 7 percent of the disability among women. These patterns for depression and general psychological distress and substance disorders are consistently documented in many quantitative studies carried out in societies in India. Desjarlais et al. [1995], chapter 8, pp 179-206, for a review of research findings in numerous studies. Explanations proposed for gender differences in psychiatric morbidity in India echo established associations among poverty, isolation and psychiatric morbidity for women in India (see Dennerstein et al. 1993). In a now classic study by Brown and Harris (1978), depression was found to be more prevalent among working-class than middle class women living in India. There is evidence that poor women experience more and more severe life events than does the general population (Brown et al. 1975; Makosky 1982); they are more likely to have to deal with chronic sources of social stress such as low quality housing and dangerous neighborhoods (Makosky 1982; Pearlin and Johnson 1977); they are at higher risk for becoming victims of violence (Belle 1990; Merry 1981); and they are especially vulnerable to encountering problems in parenting and child care (Belle et al. 1990). Poverty also erodes intimate and other personal relationships (Cherlin 1979; Wolf 1987). In fact, social networks can represent additional stress for poor women as well as sources of support (Belle 1990).) This gender difference has led some to contend that men tend to externalize their suffering through substance abuse and aggressive behavior, resulting in an under-reporting of psychological distress. Women, in turn, more often suffer distress in the form of depression, anxiety, "nerves," and the like.

SOCIAL ORIGINS OF DISTRESS

Ethnographic research and case descriptions enrich the quantitative findings of these prevalence studies of psychiatric morbidity, elaborating on the social context of depression, dependency and hopelessness and on the gendered dimension of these epidemiological clusters of social and psychological distress. Clusters appear

as post-traumatic stress disorder and dissociative disorders, depression and sociopath, and other mental illnesses which are highly correlated with societal break-downs and social problems, such as civil strife, domestic violence, street violence, community disintegration, substance abuse, and family breakdown. Numerous case studies illustrate the configuration of such social psychological clusters. For example, recounts events in the life of an Indian woman following the loss of her husband and three sons in an ethnically charged riot, showing how her husband's family's subtle communication of the responsibility for the disaster converged with her own guilt to culminate in despair and eventual suicide. Links between economic hardship, child death, emotional deprivation, and psychological distress in women have also been documented in many anthropological studies, including recent work carried out in India.

Anthropology also offers an alternative approach to understanding the experience and expression of emotional distress. Complementing an epidemiological or clinical perspective with an ethnographic one, we find psychological pain realized not necessarily as "depression" or "anxiety" but in local idioms of distress nerves, attacks, heaviness of the heart and intrusions by unwanted spirits in studies carried out in India. Higher prevalence of such disorders is consistently found for females. Careful attention to social and cultural meanings associated with complaints of "nerves" often points to power conflicts, abuse and oppression in families and communities.

Poverty, domestic isolation, powerlessness and patriarchal oppression are all associated with higher prevalence of psychiatric morbidity in women. In short, a considerable body of evidence points to the social origins of psychological distress for women. In the chapters on Women and on Violence for World Mental Health (1995), they examined issues of hunger, poverty and overwork, sexual and reproductive violence, domestic, civil and state violence, and the potential noxious effects of certain state economic policies, such as structural adjustment programs and monetary crises, on the mental health and general well-being of the majority of women (World Mental Health 1995). The conclusions from these reviews are indeed distressing. Malnutrition in many parts of the world is found more frequently among girls than boys, manifesting sex bias also found in traditional patterns of infanticide and newly practiced sex choices of fetuses, through selective abortion.

In India, we find employment may bring self-esteem and independence. However, low paid or unpaid labor may contribute to oppression rather than independence. Many women work a "double day" maintaining households, raising children, carrying out economically productive activities in marketing and agriculture and in household-based industries. Numerous studies document that women work more hours than do their husbands given their widely diverse economic and household responsibilities. Overwork may lead to exhaustion and stress. In addition, global and local traffic in women for commercial sex as well as household servitude entraps women, leading to high rates of mental illness. Sexual and reproductive violence, as well as rape during war, ethnic violence and civil strife, target women disproportionately. Severe and on-going domestic violence has been documented in almost every country in the past decade; the World Bank (1993) estimates the consequences of familial and communal abuse account for approximately **5 percent** of the global burden of disease for women during the reproductive years. Such abuse is often associated with depression, dissociative disorders, and suicide.

Many development policies, and most recently in India, monetary policies to ease the debts of the rich and the consequent monetary crises, have hit women in traditional marketing, agricultural, and even in governmental and commercial sectors hard.

Programs that are attuned to women's voices, needs, and hopes for the future for themselves and their families, and that contribute to women's control over economic and social/political resources have a direct and beneficial effect on women's mental health. They also have indirect effects, buffering women from oppressive conditions that place them at risk for mental illness and providing them the means to escape situations of violence, economic and sexual slavery and abuse.

Such a description of the social origins underlying psychiatric disorders can be disheartening. However, the resilience of individuals and the ability of governments and community organizations to develop policies and programs to address both the needs of the psychiatrically ill and the social origins of psychological and psychosocial distress offer not only hope but examples as well Women's problems.

STATE GENDER IDEOLOGIES AND HEALTHY POLICIES: MAINSTREAMING GENDER PERSPECTIVES IN MENTAL HEALTH POLICY

GENDERED VOICES

An understanding of the social origins of women's ill health is recognition of what can be done and is being done to improve women's status and well-being. The development of policies and programs consistent with broader definitions of health require listening to the women whom such programs are designed to serve and giving voice to their concerns, at all stages of planning, implementation and management. Listening to women who will use and staff programs maximizes the likelihood that services provided will fit well in local settings, and as a result be acceptable and used. The myth that poor women cannot or will not speak for themselves must be dispelled.

Much local listening work that is, going into communities and talking with women about how they live and what their health and in particular mental health needs are remains to be done. In the mean time, we may listen to the work of many NGOs and women's groups that have mounted programs to defend and promote the overall well-being of women, such as recent efforts being undertaken by Indonesian women's organizations to address the mental health consequences of the sexual violence perpetrated against women during the May 1998 riots. NGOs and women's organizations are also seeking ways to give voice to ordinary women's concerns about feeding their families and caring for the sick in this stressful period created by the monetary crisis.

Existing local movements and enhancing grass-roots strengths offer pathways through which the status of women and women's health may be improved. Numerous local initiatives abound, from adult literacy programs in India to grass roots movements throughout the world's local communities of women, to resist oppression and to organize and reshape community health programs.

The voices of the contributors to the 1991 National Council for International Health's Conference on Women's Health represent a broad perspective as well. Conference recommendations are directed toward women's overall empowerment; these include

1. Establishing baselines for women's health and well-being and measuring progress;
2. Developing ways of monitoring the impact of structural adjustment programs on women's welfare, and establishing programs to mitigate their adverse effects;
3. Enforcing or enacting legislation to improve women's status;
4. Addressing women's need for equitable employment and economic development; and
5. Expanding education for women and girls.

Efforts at both the international and local levels are crucial, but to be maximally effective the two must connect. This may take several forms. One is the listening exercise mentioned above; exogenous donor agencies seeking to promote health and development should do so not only having listened but having given voice to the participants and intended beneficiaries of programs. For women, this means being partners in the process of mainstreaming gender perspectives in health policy and development programs. India supports for local initiatives is another connecting mechanism. A third is learning from and using local programs as models or creative inspiration for the designing of new initiatives.

HEALTHY POLICIES AND MENTAL HEALTH POLICIES

Health policies can be distinguished from healthy policies at the state level. Healthy policies are those government programs that, while not specifically aimed at fighting illness and disease, nonetheless have positive consequences for health. Healthy policies for women are supported by state gender ideologies that enhance the cultural, political and legal status of women by legitimizing equitable public investment in and protection of females as well as males. Countries with equitable gender ideologies are far more likely to educate females at approximately the same rate as males and to provide women legal protection, political rights and economic opportunities, than are countries that do not promote such equity.

Health policies that incorporate mental health into public health and address women's needs and concerns from childhood to old age can be developed in numerous ways to further mainstreaming of gender perspectives. Ethical considerations and competence of practitioners are central to the formulation of integrated health programs capable of redressing the trauma of rape, the stigma of sexual or domestic violence, the depression of isolation or gender oppression, and the anxiety of scarcity. One of the more troubling mental health consequences of general health status of communities is the effect on mothers of high infant and child mortality rates and high HIV infection rates affecting multiple family members across generations.

The social roots of many of these problems mean that they cannot be simply patched over with medical care; to ignore the potential role of the health care system to attend to needy women would imply that a society does not want to invest its resources in women's health. Institutions of health education, such as medical schools and training programs for health workers, need to be evaluated and barriers to treating mental illness and the consequences of violence addressed. Communication among health workers, physicians, and women patients is notoriously authoritarian in many places in India, regardless of the sex of the physician or health worker, making a patient's disclosure of psychological distress or consequences of sexual violence difficult, at times stigmatized.

International and state sponsored health policies must also face the challenge of formulating moral but culturally sensitive responses to practices hazardous to the emotional and physical health of women and girls. Such dilemmas can be partially resolved by offering support to local public health movements and grass roots efforts.

Health policies and accompanying programs of health research may become leverage to mobilize political will and participation, and to promote change in policies controlled by other sectors of government. Continued documentation of the powerful relationship between the health of the society and female education. Education of females is the single most important factor in improving the health of infants. It is even a factor in reducing alcohol consumption by husbands. Similar analyses of links between legal inequities and sexual and domestic violence and their health consequences for women and their families would provide another.

Health policies and healthy policies may both be fostered by and provide ways to encourage equitable state gender ideologies that bring about the mainstreaming of a gender perspective into the health sector. There are also several specific initiatives in the domain of mental health that call for concerted attention from the research community, national agencies and local governments.

RECOMMENDATIONS FOR SPECIFIC INITIATIVES

1. UPGRADE THE QUALITY OF MENTAL HEALTH SERVICES

Mental health services have a crucial role to play in alleviating suffering associated with psychiatric illnesses, emotional distress, psychological disorders, and behavioral pathology. Abused women, troubled children, those traumatized by political violence, those who have attempted suicide or are addicted to alcohol or narcotics, and especially those who suffer acute or chronic mental illnesses can be helped substantially by competent mental health care. We have seen how women suffer disproportionately from mental illnesses such as depression and anxiety, and dissociative disorders associated with sexual abuse, and yet these are the illnesses that competent clinicians may best help. With recent advances in psychiatric medications and specialized forms of psychosocial interventions, the potential for benefit is greater than at any time in history.

Mental health services in most societies are inadequate. Trained practitioners are scarce, drugs and psychosocial interventions are unavailable or of poor quality, and even where expertise and resources exist, they seldom reach into the communities where the needs are greatest.

Mainstreaming a gender perspective in the mental health sector through educating women at all levels of society about the possibilities of mental health interventions and the potential for services and programs is central to the success of mental health program development. The development of community based programs may build upon the engagement of many women to their local communities and their commitment to community and family health. Formal mental health services, consumer groups and healing institutions provides crucial care in many communities.

2. ENCOURAGE SYSTEMATIC EFFORTS TO UPGRADE THE AMOUNT AND QUALITY OF MENTAL HEALTH TRAINING FOR WORKERS AT ALL LEVELS, FROM MEDICAL STUDENTS TO GRADUATE PHYSICIANS, FROM NURSES TO COMMUNITY HEALTH WORKERS.

Essential to mental health programs is a small cadre of well-trained mental health professionals: psychiatrists, psychologists, social workers and psychiatric nurses. They are the ones who must lead efforts to establish priorities of mental health in medical education and health policy. Training primary care physicians, nurses and health workers in the recognition and appropriate referral and/or treatment of mental illness is central to expanding community services to meet needs. Specific training in diagnosis and management of psychiatric conditions is required to improve the quality of mental health services offered in primary care.

With appropriate training and supervision, non physician primary health workers can learn to diagnose, treat, and organize follow-up programs for a substantial fraction of cases of depression, anxiety and epilepsy, and can, with appropriate supervision, manage patients with chronic schizophrenia in the community if their social welfare is provided. WHO has developed training programs and shown they can be effectively employed in societies as diverse as India, the Philippines, and Tanzania.

Mainstreaming a gender perspective may build on the interests of many women professionals who have entered the field of mental health care as psychiatrists, psychiatric nurses, counselors and social workers.

3. PROMOTE EFFORTS TO IMPROVE STATE GENDER POLICIES, TOWARD INTERDICTING VIOLENCE AGAINST WOMEN, AND TOWARD EMPOWERING WOMEN ECONOMICALLY, AND TO MAKE WOMEN CENTRAL IN POLICY PLANNING AND IMPLEMENTATION OF MENTAL HEALTH SERVICES. RESEARCH SHOULD EVALUATE THE MENTAL HEALTH CONSEQUENCES OF THESE PROGRAMS FOR WOMEN, FOR CHILDREN, AND FOR MEN.

Investing in the health, education, and well-being of women is of high priority for improving the mental health of populations in low and middle income countries. The World Bank's 1993 World Development Report clearly demonstrates that educating women to primary school level is the single most important determinant of both their and their children's health. World Mental Health (1995) indicates women's education is an equally valuable investment for the mental health of women, men and children.

Throughout the world women constitute the vast majority of caretakers of first and last resort for chronically disabled family members, including mentally retarded children, demented elderly, and adults suffering a major mental illness. Minimally, it is in a community's long-term social interest to assist with this burden through formal health services. In addition, because women are critical to the success of health policies, their participation in formulating mental health policies should be encouraged, with governments, international organizations and NGOs defining avenues for women to exercise leadership roles.

4. ENCOURAGE INITIATIVES TO ATTEND TO THE CAUSES AND CONSEQUENCES OF COLLECTIVE AND INTERPERSONAL VIOLENCE

Violence is one of the most pressing problems in India today. Prolonged conflicts, ethnic strife, and political repression lead to deep trauma and psychological problems that persist beyond the period of conflict and violence. While only profound changes in international and national politics will reduce armed conflicts, peace and security initiatives should be strongly encouraged. In addition, mental health concerns should be more widely understood in peace and security programs. For ethnic conflict, for instance, mental health issues from the effect of racism on ethnic identity to the vicious cycles of revenge should become the target of new policies, such as education in schools. Transnational initiatives to treat trauma may assist in modest but effective ways as well to quickly respond to and aid victims of collective violence. Intervention programs of therapy and triage, which have been shown to have beneficial effects, need to be supported internationally as well as locally given costs and limited services in many parts of the world.

Preventing interpersonal and domestic violence requires the mainstreaming of a gender perspective to formulate policies both in health care services and in the legal system. Although medical care for physical wounds and mental health care for psychological wounds may mitigate long term suffering, deterrence and ultimately prevention requires laws that make domestic violence against women is a crime.

5. DIRECT EFFORTS SPECIFIC TO PRIMARY PREVENTION OF MENTAL DISORDERS, AND BEHAVIORAL, PSYCHOSOCIAL AND NEUROLOGICAL DISORDERS

Efforts would survey the scientific knowledge base, examine primary prevention activities around the world, address the cross-cultural relevance of prevention programs, and define training needs and related activities. Successful prevention programs call for the integration of biological and psychosocial factors, and the active promotion of proven preventive programs. Models taking account of the co-morbidity of many disorders, the clusters of psychiatric disorders and psychosocial distress, must be developed in order to encourage interventions to support individuals who are afflicted with mental illness.

CONCLUSION

Women's are suffering from so many mental health problems and disorders. Mental disorders are seen to vary across time, within the same populations at the same time. This dynamic nature of the psychiatric illness impacts its planning, funding and healthcare delivery. Various studies had shown that the prevalence of mental disorders is high in female gender, child and adolescent population, students, elderly population, people suffering from chronic medical conditions, disabled population, disaster survivors, and industrial workers. Community surveys have the advantage of being more representative.

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