1.1 INTRODUCTION

Many women with mental health and substance abuse disorders and histories of trauma are parents who value their roles as mothers and bring skills to the task. Historically, treatment for these women has never been considered the important due to women’s roles as mothers and otherwise their children. Acknowledging their roles as parents and incorporating this reality into service design and delivery can optimize treatment, as has been hoped by researchers around the globe.

Women with a portion to over of half population in the world, especially in developing country like India, should take into consideration any community based mental health programs. Women’s significant roles in global development of society, child rearing, family endorsement and workplace, their mental health influence by many socio-cultural factors (Navabi-Nejad, 2000). In contrast to women’s participation as the paid labor force during the recent decades that increased in country too, the major lines of
women’s psychology investigation has mostly focused to the effects of child care and maternal employment in children rather than their psychic well-being (Khodarahimi, 2005). While universal growing literature has examined the effect of women's multiple roles on their own physical and mental health, and indicated their multiple roles have negative health outcomes for them.

Social inequality has damaging consequences for the mental and emotional well-being of women. Throughout their lives, women may be considered "at risk" of developing emotional problems due to a host of social factors. Limited participation in public life, restricted decision-making, devalued role expectations, poverty, violence and sexual abuse undermine the potential for emotional well-being. Social change is needed to strengthen the emotional well-being of women individually and collectively in society.

Women are integral to all aspects of society. However the multiple roles that they play in society render them at greater risk of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mother and career minders of others. Increasingly, women are becoming an essential part of the labour force and in one quarter to one third of households they are the prime source of
income. (WHO, 1995). In addition to many pressures placed on women, they have to bear gender discrimination and the associated factors of poverty, hunger, malnutrition and overwork. An extreme but common expression of gender inequality is in sexual and domestic violence, perpetrated against women. These forms of socio-cultural violence, contribute to the high prevalence of mental problems experienced by women.

The Magna Carta in England considered all men equal before law. Yet when higher education systems opened and women started applying, one Dean remarked “We are running a University, not a bathing institution” when women did secure admissions, the science stream showed streaks of difference in the of students – women were compelled to pursue home science, botany etc., and were not allowed admissions in the field of pure science microbiology etc.,.

When the French Revolution demanded liberty, equality and fraternity, liberty was meant for men, equality was not demanded between men and women and fraternity was to be between brother Frenchmen. In the 19th century America, the issue of equality of the sexes elicited mixed response even at a highest bench. The claim of one Myra Bradwell for admission in the Bar was denied by
the Supreme Court. This state of affairs, though legally ignored out in the latter Century, still leaves traces of similar mindset, in the society.

Millions of women in India suffer from co-occurring substance abuse and mental health conditions. A substantial majority of women with these co-existing conditions have also experienced violence. Women who struggle to overcome these problems are likely to have more severe difficulties and use services more often than women with any one of these problems alone. Because services tend to be fragmented, and treatment philosophies can be inconsistent, these women face barriers to adequate care. Chief among these barriers is the fact that many of these women are mothers caring for dependent children. No comprehensive data has documented the number of women with co-occurring conditions and trauma who are mothers. Large-scale surveys do not emphasize the role of motherhood and public health departments generally do not keep statistics on parenting rates. One exception, a study of women using illicit substances in a large urban area, demonstrated that 60% to 70% of respondents have children. A number of these women do not have custody of their children, but
their identities as mothers are still primary and many want to reunify with their children.

Most women with co-occurring conditions and trauma histories view parenting as the central purpose and defining role of their lives. For them, motherhood is both a major source of identity and self worth, and a source of shame and guilt. Their "mothering" can be a primary motivation for entering treatment or a deterrent to seeking care. In short, a woman's identity as a mother, figures importantly into her self-esteem, behaviors, and treatment decisions.

When the world of health policy and public health considers the health of women, one tendency is first and foremost to link the well-being of women to that of children and the family, and, legitimately, to the health of society overall. Although this perspective is well-founded, given that the health of women is well documented to have a positive impact on the general health of all members of a society, too often a common focus among health policy decision makers is to emphasize maternal and child health. Women's health within the policy domain is often defined as reproductive health and identified with women's children's health. Family planning efforts, inspired by the theory that overpopulation
is a major impediment to development, have dispensed contraceptives in the interests of reducing fertility, but often ignored women's needs for information about, and control over, reproductive processes. More recently, clinical trials of AZT during pregnancy have focused on reducing the transmission of HIV from infected mothers to their newborns, but financial constraints have limited efforts to provide AZT for mothers after pregnancy.

Such efforts to improve the health of women's children through programs that affect women's health are laudable. Yet, in the past decade, as women have begun to exercise greater influence over health policy formation, questions about such trends have been raised. Initially, women asked "Where is the "M" in MCH programs?" "What about programs designed to address women's needs as women as well as mothers?" Such questions challenge traditional health policies that focus primarily on MCH programs; the call for definitions of women's health which are broader than the reproductive and the maternal, incorporating mental and physical health across the life cycle, has been repeatedly expressed in recent years. As feminist theorists have recently argued, women's well-being is "not solely determined by biological factors and reproduction, but also by the effects of workload, nutrition,
stress, war, migration." Mainstreaming a gender perspective into the health sector requires a broad-based definition of health for women as well as men that address well-being across the life cycle and in domains of both physical and mental health. Mainstreaming a gender perspective needs to be coupled with mainstreaming mental health issues as well, because women disproportionately suffer from mental health disorders and are more frequently subject to social causes that lead to mental illness and psychosocial distress.

1.2 THE RIGHTS AND ROLE OF WOMEN IN THE SOCIETY:

Women hold a significant position of distinct character in every social structure. The pursuit of women's issues took its birth along with the Industrial Revolution in England at the end of 18th and beginning of 19th century. Prior to Industrial Revolution women had no say or opportunity to express themselves. Even if they did, their voices were unheard. Right from the evolution of the universe down to the modern world the written record of history provides an ample testifying evidence to show that, with the exception of a few royal and intellectual women, whose number was just meager the total of women folk had no say in any sphere of life.
In that it is, and ought to become, a commission and community of persons, the family finds in love the source and their constant impetus for welcoming, respecting and promoting each one of its members in his or her lofty dignity as person that is, as a living image of God. The moral criterion for the authority of conjugal and family relationships consists in fostering the dignity and vocation of the individual persons, who achieve their fullness by sincere self-giving. In this perspective special attention is to be focused on women in respect of their rights and role within the family and society. In the same perspective are also to be considered men as husband and father, and likewise children and elderly.

Above all it is important to underline the equal dignity and responsibility of women with men. This quality is realized in unique manner in that reciprocal self-giving by each one to the other and by both to the children, which is proper to marriage and the family.

The history of salvation, in fact is a continuous and luminous testimony to the dignity of women. In creating the human race “Male and Female” God gives men and women an equal personality, endowing them, the inalienable rights and responsibilities proper to the human person. Without intending to deal with various aspects
of vast and complex theme of the relationships between women and society and limiting these remarks to a few essential points, one cannot but observe that in the specific area of family life a widespread social and cultural tradition has considered women’s role to be exclusively that of wife and mother, without adequate access to public functions, which have generally been reserved for men. On the other hand the true advancement of women requires that clear recognition be given to the value of their natural and family role, by comparison with all other public roles and all other profession. Furthermore, these roles and professions were harmoniously combined in the evolution of society and culture to be truly and fully to make man a human. This will come about more easily if “Theology of work” can shed light and study the meaning of work in the life and determine the fundamental bond between the work and family and therefore the original and irreplaceable meaning of work in the home be recognized and accepted by all in its irreplaceable value.

This is of particular importance in education: For possible discrimination between the different types of work and profession is eliminated as its very root once it is clear that all people in every area are working with equal rights and equal responsibilities. The
image of God in man and in women will thus be seen with added luster. While it must be recognized that women have the same right as men to perform various public functions, society must be structured in such a way that wives and mothers are not in practice compelled to work outside the home, and that their families can live and prosper in a dignified way even when they themselves devotes their full time to their own family. Furthermore, the mentality, which honors women more for their work out side the home than for their work within the family must be overcome. This requires that men should truly love women with total esteem and respect of their personal dignity, and that society should create and develop conditions favoring work in the home.

1.3 DIFFERENCE OF GENDER IN MENTAL HEALTH

Gender refers to culturally and socially determined differences between men and women. It is related to how people are perceived and expected to think and act as women and men because of the way society is organized, not because of our sex (which refers to biologically determined characteristics).

Gender influences how much control men and women have over key aspects of their lives that can affect mental health, such
as economic position and social status. Research that takes gender into account is considered to lead to better treatments and outcomes.

Gender awareness in mental health is required in law. The Equality Act (2010) reinforces the legal status of the Gender Equality Duty, which requires all public bodies to eliminate unlawful discrimination and harassment on the grounds of gender, and to promote equality of opportunity between women and men. All mental health and social care organizations have a duty to prepare gender equality policies for staff and services, to consult their stakeholders and to monitor the impact of their policies annually.

1.4 GENDER INEQUALITY AND RISKS TO WOMEN’S MENTAL HEALTH

Gender inequality in society leads to differences in the life experiences of men and women, which affect mental health in different ways. Gender inequality is described as a system that tends to give more advantages to men in terms of employment, status and ownership. Women are much more often expected to
look after others in the home or in society, often doing work that is undervalued and unpaid or poorly paid.

Some risk factors for mental health problems affect women more often than men. These include gender-based violence, social and economic disadvantage, low income and income inequality, low or subordinate social status and rank, and major responsibility for the care of others.

Mental illness is associated with a significant burden of morbidity and disability. Lifetime prevalence rates for any kind of psychological disorder are higher than previously thought, are increasing in recent cohorts and affect nearly half the population. Despite being common, mental illness is under diagnosed by doctors. Less than half of those who meet diagnostic criteria for psychological disorders are identified by doctors.

Chowdhary and Patel (2010) have studied that patients, too, appear reluctant to seek professional help. Only 2 in every 5 people experiencing a mood, anxiety or substance use disorder seeking assistance in the year of the onset of the disorder. Overall rates of psychiatric disorder are almost identical for men and women but striking gender differences are found in the patterns of mental illness. Unipolar depression, predicted to be the second leading
cause of global disability burden by 2020, is twice as common in women. Depression is not only the most common women's mental health problem but may be more persistent in women than men. More research is needed.

Reducing the overrepresentation of women who are depressed would contribute significantly to lessening the global burden of disability caused by psychological disorders.

The lifetime prevalence rate for alcohol dependence, another common disorder, is more than twice as high in men than women. In developed countries, approximately 1 in 5 men and 1 in 12 women develop alcohol dependence during their lives. Men are also more than three times more likely to be diagnosed with antisocial personality disorder than women. There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect less than 2% of the population.

Gender differences have been reported in age of an onset of symptoms, frequency of psychotic symptoms, course of these disorders, social adjustment and long term outcome. The disability associated with mental illness falls most heavily on those who
experience three or more co-morbid disorders. Again, women predominate.

1.5 GENDER STEREOTYPING AND BIAS

Both women and men can be adversely affected by gender-based assumptions, stereotypes and social pressures. For example, beliefs that women are emotionally or psychologically vulnerable, while men are strong, can be unhelpful for people’s mental health. A World Health Organization (WHO) report claims that researchers have over-emphasized the impact on women’s mental health with the biological factors such as menstruation, pregnancy and childbirth. The report says that the impact on women’s mental health often has more to do with what is happening in their social and emotional lives than with biological changes. Gender bias occurs in the treatment of psychological disorders. Doctors are more likely to diagnose depression in women compared with men, even when they have similar scores on standardized measures of depression or present with identical symptoms. Female gender is a significant predictor of being prescribed mood altering psychotropic drugs.
Women are more likely to seek help from and disclose mental health problems to their primary health care physician while men are more likely to seek specialist mental health care and are the principal users of in-patient care. Men are more likely than women to disclose problems with alcohol use to their health care provider.

Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men, appear to reinforce social stigma and constrain help seeking along stereotypical lines. They are a barrier to the accurate identification and treatment of psychological disorder. Despite these differences, most women and men experiencing emotional distress and / or psychological disorder are neither identified nor treated by their doctor. Violence related mental health problems are also poorly identified.

Women are reluctant to disclose a history of violent victimization unless physicians ask about it directly. The complexity of violence related health outcomes increases when victimization is undetected and results in high and costly rates of utilization of the health and mental health care system.
1.6 GENDER DIFFERENCES IN MENTAL HEALTH DISORDERS

Women receive more services than men for mental health problems at the level of primary care, though this difference is less at the level of secondary care (specialist and hospital treatment). It is difficult to know whether more mental health problems are diagnosed in women at primary care level because they seek help more often than men, or because they actually experience more distress.

According to another WHO report, there is little difference in the prevalence of mental health disorders between men and women, but the types of disorders and the stages of life at which mental health problems are most likely to be diagnosed differ. In childhood, boys are more often identified as having mental disorders, such as attention-deficit hyperactivity disorder, and substance abuse is more common. Young women experience more depression, self-harm and eating disorders. In adulthood, women are far more likely to be diagnosed with depression. Psychotic disorders such as schizophrenia and bipolar disorder are similarly likely in both sexes. In old age, women are more likely to be diagnosed with depression and psychoses. Women are more likely
than men to have more than one disorder, which increases disability.

1.7 WOMEN AND MENTAL HEALTH

Mental illnesses affect women and men differently — some disorders are more common in women, and some express themselves with different symptoms. Scientists are only now beginning to tell apart the contributions of various biological and psychosocial factors to mental health and mental illness in both women and men.

Mental health problems affect women and men equally, but some are more common among women. Abuse is often a factor in women’s mental health problems. Treatments need to be sensitive to and reflect gender differences. The same numbers of women and men experience mental health problems overall, but some problems are more common in women than men, and vice versa. Various social factors put women at greater risk of poor mental health than men. However, women’s readiness to talk about their feelings and their strong social networks can help protect their mental health.
1. **Women as guardians of family health**: However busy they are, it is important that women look after their mental health. Traditionally, women have tended to take on the responsibility of looking after the health of members of their family as well as themselves. For instance, women often shop for their family and influence what they eat or advise their family when they feel unwell. This role makes it particularly important that women understand how the choices are made in everyday life can affect mental health.

2. **Career Women**: Careers women are more likely to suffer from anxiety or depression than women in the general population. Three quarters of people who care for a person with a mental health problem are women and the average age of careers is 62 years.

3. **Mental health of women in mid-life**: Women in ‘mid-life’, aged 45–60 years, may be juggling caring commitments for children and older relatives as well as doing paid work and facing physical health problems. At the same time, mid-life women may find themselves in financial difficulty as a result of lifelong lower pay, part-time working, family caring,
widowhood or divorce. This combination can increase their risk of experiencing mental distress.

4. **Social support**: Women’s friendships with other women help protect their mental health, providing a source of support, particularly in hard times or at times of loss or change. Mentally healthy women generally talk about their feelings more than men and more often have stronger social networks of friends and family. They are more likely to tell someone when they are troubled, whether it is someone they are close to or someone who can offer medical advice. Good social support can play a part in preventing mental ill health and can help people recover from mental health problems.

5. **Women’s Mental Health**: There are no significant differences between the numbers of men and women who experience a mental health problem overall, but some problems are more common in women than in men. Women are more likely to have been treated for a mental health problem than men (29% compared with 17%). This reflects women’s greater willingness to acknowledge that they are in trouble they do not get support. It may also reflect doctors’ expectations of
the kinds of health problem that women and men are likely to encounter. About 25% of people who die by committing suicide are women. Again, women’s greater emotional literacy and readiness to talk to others about their feelings and seek help may protect them from suicidal feelings. Being a mother also makes women less likely to take their own life. Women are particularly exposed to some of the factors that increase the risk of poor mental health because of the role and status that they typically have in society. The traditional roles for women from some ethnic groups living can increase their exposure to these risks.

The social factors particularly affecting women’s mental health may include:

- more women than men are the main caretakers for their children and they may care for other dependent relatives too – intensive caring can affect emotional health, physical health, social activities and finances
- career women often juggle with multiple roles – they may be mothers, partners or doing paid work and running a household
women are over represented in low income, low status jobs – often part-time – and are more likely to live in poverty than men

- poverty, working mainly in the home on housework and concerns about personal safety can make women particularly isolated

- physical and sexual abuse of girls and women can have a long-term impact on their mental health, especially if no support has been received around past abuses.

- Mental health problems affecting more women than men

Some women find it hard to talk about difficult feelings and ‘internalise’ them, which can lead to problems such as depression and eating disorders. They may express their emotional pain through self-harm, whereas men are more likely to ‘act out’ repressed feelings, and to use violence against others.

6. **Depression**: More women than men experience depression.

One in four women will require treatment for depression at some time, compared with one in 10 men. The reasons for this are unclear, but are thought to include social factors,
poverty, isolation and biological factors such as the hormonal changes experienced by women. However, some researchers dispute the relatively low depression rate for men. Post-natal depression is believed to affect between eight and 15% of women after they have given birth. Women’s increased life expectancy means they are more likely than men to outlive their partner and move into residential care. This means they are more at risk of depression associated with psycho-social factors. Older people are often faced with more difficult life events and daily stresses than younger people and this may explain why they have a slightly increased risk of depression. Losses – whether bereavement or losses associated with growing old such as loss of independence because of physical illness or disability – can trigger depression. Estimates suggest that 20% of older people living at home have symptoms of depression, rising to 40% for older people living in care homes. The majority of people affected are women. Those over the age of 85 are at particular risk.

7. **Self-harm**: Many girls than boys self-harm themselves. Research suggests that between one in 12 and one in 15 young people self-harm in the UK.
8. **Anxiety**: Women are twice as likely to experience anxiety disorders as men. About 60% of the people with phobias or obsessive compulsive disorder are women. Phobias affect about 22 in 1,000 women in the third world countries, compared with 13 in 1,000 men.

9. **Dementia**: Two thirds of people with dementia are women. Risk of dementia increases with age, and women have a higher life expectancy than men.

10. **Eating disorders**: Eating disorders are more common in women than men, with young women most likely to develop one. 1.9% of women and 0.2% of men experience anorexia in any year. Between 0.5% and 1% of young women experience bulimia at any one time.

11. **Post-traumatic stress disorder (PTSD)**: Worldwide, more women are affected by PTSD than men, largely because women are exposed to more sexual violence. The risk of developing PTSD after any traumatic event is 20.4% for women and 8.1% for men.

*Source: International Review of Psychiatry (2010) December*
Many initiatives to improve services for women still have a long way to go. Women have been calling for more support for self-help and alternatives to medicalised treatments for many years, but in most cases these alternatives are not well supported financially, and are usually left to the voluntary sector to provide, and therefore not universally available.

1.8 PROMOTING WOMEN’S MENTAL HEALTH

It is essential to recognize how the socio-cultural, economic, legal, infrastructural and environmental factors that affect women's mental health are configured in each country or community setting. A gender-based, social model of health needs to be adopted to investigate critical determinants of women's mental health with the overall objective of contributing to improved, more effective promotion of women's mental health. Risk factors for mental disorder as well as for good mental health need to be addressed and where possible, a clear distinction should be made between the opportunities that exist for individual action and individual behaviour change and those that are dependent on factors outside the control of the individual woman.
Women's views and the meanings they attach to their experiences have to be heeded by researchers, health care providers and policy makers. Without them, research and the evidence it gathers, service delivery and policy formation, will be hampered in responding to women's identified health priorities, problems and needs. Moreover, all three will be ignorant of the nature and magnitude of unmet needs and unaware of the factors influencing women's utilisation of health care. The identification and modification of the social factors that influence women's mental health holds out the possibility of primary prevention of certain mental disorders.

In the light of this discussion the present study will help to know about the level of awareness and attitudes of the people regarding mental illness. This is very important because the lack of knowledge and awareness regarding appropriate help sources lead to the inevitable use of multiple coping techniques, which, many a times prove ineffective. The families tend to follow different course before bringing their mentally ill family members to the mental hospital. Much time is lost in following these pathways and by the time the person is brought to the hospital the damage is already done. This is added by the fact that mental health scene in general
has been dominated by western logic and values that emphasize cure and the problems within a 'patient', ignoring prevention and the impact of destructive attitudes towards women in the environments in which they live and work. Studies both in India and abroad lack in the area of knowing reason for the essential factors that create stress and mental health problems for women. Hence, there is an urgent need for taking up studies for eliciting the pertinent information.

The morbidity data for the urban mental health can provide an idea about the needs, both current and projected. In order to remove myths and misconceptions about mental illness and to help recognize it during the early stage to reduce the disability caused by it, there is an urgent need for adequate information on peoples' levels of awareness about mental illness, mental health services, the treatment followed by families and about other important variables that impede access of poorer sections especially women to the mental health services.

As feminist theorists have recently argued women’s well being is “not solely determined by biological factors and reproduction, but also, by the effects of work load, mutation, stress, war, migration. Main streaming a gender prospective into the health sector requires
a broad–based definition of health for women as well as men that addresses well being across the lifecycle and in domains of both physical and mental health issues as well, because women disproportionately suffer from mental health disorders and are more frequently subject to social causes that lead to mental illness and psychological distress. It is essential to recognize how the socio-cultural, economic, legal infrastructural and environmental factors that affect the women’s mental health are configured in each country or community setting. A gender–based social model of health needs to be adopted to investigate critical determinants of women’s mental health with the overall objective of contributing to improve, more effective promotion of women’s mental health. Risk factors for mental disorders and good mental health need to be addressed and where possible, a clear distinction may be made between the opportunities that exist for individual action and individual behavior change and those that are dependent on factors outside the control of individual woman.

To help clarify the meaning themselves ascribe to mental health and various forms of psychological distress findings from qualitative research need to augment those from quantitative research. Descriptions of life situations, case studies and direct
quotes from women themselves can verify the contexts in which emotional distress, depression, anxiety and other psychological disorder occur. Such first hand accounts of the experience of poverty, inequality and violence will assist in developing a more accurate understanding of the structural barriers women face in attempting to exercise control over the determinants of their mental health and in effecting behavioral change. Both are needed to better inform the promotion of women’s mental health.

Comparative analysis of empirical studies of mental disorders reveals constancy 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, whereas substance disorders are more prevalent among men. 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 (1955) dealing with the issues of hunger, poverty and overwork, sexual and reproductive violence and the rational 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.
In the world of work, employment may bring self-esteem and independence, however low paid or unpaid labour 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 base industries.

The World Bank (1993) estimates the consequences of familial a communal abuse account for approximately five percent of the global burden of disease for women during the reproductive years. Such abuse is often associated with depression, dissociate disorders, and suicide. It took United Nations “Decade for Women” to begin to make women’s productive, as well as reproductive, roles visible to the world, Just as important as an understanding of social origins of women’s ill health is a recognition of what can be done is being done to improve women’s status and well being. These development policies and programs consistent with broader definitions of health require listening to the women whom such programs are designed to serve and giving voice of their concerns, at all stages of planning, implementation and management. 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.

Mental health services have a crucial role to play in alleviating suffering associated with psychiatric illness, emotional distress, psychological disorders, and behavioural 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 illness and uphold subsequently by competent mental health care.

1.9 NATURE OF ABUSE EXPERIENCED BY WOMEN

Distinguishing dynamics can be specified as follows;

- Multiple abusers: parents, siblings, in laws, wives and partners
- More cumulative effects because different perpetrators collude
- More threats of rejection (to divorce, send back to country of origin)
- Rigid gender roles tightly prescribing the role of women
- Prevalent patriarchal family system, including belief that children belong to the father and that women are possessions rather than independent
- Divorced women more severely stigmatized
- Women escaping civil war may suffer violence in the wider society
- Forced Marriages
- Threat of being murdered by their own family if they were to leave
- Language and cultural barriers to accessing help
- Physical violence can mean
- A broader range of homicides through ‘honour’ killing, contract killing, dowry (bride-price) related deaths
- Killing or injuring family members in the home country
- Physical assault, stalking or hunting by many people
- Kidnapping or separation from children
- Severe exploitation of household labour akin to slavery, including mistreatment of elderly women and widows

**Sexual Violence can mean**

- Trafficking, including mail order brides, sex workers, indentured workers
- Sex following forced marriage (not consensual arranged marriage)
- Rape (vaginal, oral, anal) with lack of awareness of legal rights
o Forced unprotected sex resulting in STIs, including AIDS
o Single women being sexually harassed by family, work colleagues
o Excessive restrictions to control sexuality; grave threats about sexual activity (which may be enacted)
o Blamed for rape, incest; being forced to marry the rapist
o Denied sexual orientation in community where homosexuality is ostracized
o Kept in ignorance about sex and sexual health

**Psychological Abuse can mean**

o Severe isolation including removal of all support systems
o Threats of abandonment, deportation or forced return to their home country
o Loss of children by removal; separation from them within the family
o False declarations to immigration; withholding/ hiding passports
o Withholding proper nourishment, education
o Control of income or benefits
o Withholding health care or medication
1.10 BARRIERS TO DISCLOSING DOMESTIC VIOLENCE

Nature of Abuse

- Suffering abuse from more than one perpetrator in the extended family
- Fear of breach of confidentiality, particularly in case the family finds out
- Threats of being sent abroad
- Threat of being excluded from or shamed by the community
- Fear of consequences from being found if they do leave

Cultural Norms

- Fear of bringing shame to and going against the family tradition and cultural norms
- Religious belief that marriage is sacred
- Belief that the children need their father
- Fear of becoming a hindrance to siblings’ marriages

Cultural Pressures

- Grooming from birth for girls makes it difficult to challenge male authority
- Duty and tradition means being taught to respect authority figures
A woman is taught to be a perfect mother, a perfect wife and a perfect daughter-in-law

Girls are taught from an early age “Don’t take your problems outside the home”

The view that it’s a stigma to talk about violence with strangers

The view is that domestic violence is normal and justified if a woman steps outside of expected role

Women are taught that men are superior and thus “your husband has the right to beat you”

It is bad karma (against religious beliefs) to leave.

**Suffering is a part of Spiritual Life**

Sexual abuse can be justified if it will produce a son or “heir”

A woman can lack support from her own family as well as her extended family

A woman married into a different culture and asked to convert to a different faith can feel even more scared and stuck

If women do try to disclose, not being believed is a barrier
Lack of Support

- Risking immigration status
- No recourse to public funds and therefore unable to access refuges
- Lack of English language skills increasing isolation
- Lack of confidence in dealing with statutory organisations
- Lack of social support in the neighbourhood
- Bad experience of services

Barriers to Disclosing Mental Distress

In addition disclosing mental distress alongside domestic violence is difficult for women due to the following reasons:

- It’s acceptable to have numerous physical problems but not a mental health issue
- A woman might be considered to be “pagal” (mad)
- There is pressure to be a “good” wife and mother
- A woman may feel under pressure to keep it a secret from everyone, because she is a disgrace to the family
- Many women only seek help at a crisis point
- Women lack knowledge about mental health issues and support available
A woman can be afraid of being labeled “mental” and find it difficult to express how she really feels because of the language barriers.

Fear of losing children if they are seen to have a mental health issue and abusers prove they are unfit mother.

1.11 PRECAUTIONARY STEPS FOR MENTAL HEALTH PROBLEM WOMEN

Health professionals are in a unique position to help women who are experiencing domestic violence as they will come into contact with them at some point through the services they provide. By providing a safe environment in which women feel they can disclose, information and support can be made available which could potentially save their lives and certainly make a difference to them and their children.

Health professionals are often a first point of contact for women and they deal with the aftereffects of domestic abuse on an everyday basis. Women who have experienced abuse use health services frequently and require wide-ranging medical services. They are likely to be admitted to hospital more often than non-abused women and are issued more prescriptions. Due to lack of contact
with other professionals. Women at risk might not come into contact with any other professionals. Thus, because women experiencing domestic violence are typically isolated from sources of support, their interaction with health professionals may be a critical window of opportunity.

Time and again survivors of domestic abuse have said they wish somebody had asked them if they were experiencing problems in their personal relationships.

1.12 WHO’S (2011) FOCUS IN WOMEN’S MENTAL HEALTH

Build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors. Promote the formulation and implementation of health policies that address women's needs and concerns from childhood to old age. Enhance the competence of primary health care providers to recognize and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women.
OVERVIEW OF WOMEN WITH MENTAL HEALTH PROBLEMS

- Display information about support services in a range of languages
- Recognize the ways in which women might communicate distress
- Ask questions if it is safe and no-one can overhear
- Be alert to the fact that an woman might not approach you until she has reached a crisis point and therefore needs a rapid response
- Validate women’s experience. Link domestic violence and poor health
- Keep detailed, accurate records (safely)
- Emphasize confidentiality but share information for effective support
- Refer to appropriate services. Provide resources (for example a telephone, interpreter, computer) for her to access support.
- Monitor, evaluate and review interpreter provision. Provide first language services where possible
- Attend to all the woman’s needs rather than presenting symptom
- Talk through risk assessment and safety planning for example advise not to travel abroad
- Follow up, including safe means to assess and check DNA’s or cancellations

**The Issues**

Women represent 65 percent of patients in mental institutions. Twice as many women as men are prescribed psychotropic medications. There are two common explanations for the over-representation of women in the mental health system.

**Social Factors**

Women are more likely to be diagnosed as mentally ill because of sex role stereotyping, which assumes that women are more prone to emotional distress because of social factors specific to their gender role. This leads psychiatry to expect and encourage women to behave and feel in ‘feminine’ ways. Those who deviate from the norm of their ascribed role are more likely to be treated as mentally ill.

It is more socially sanctioned for women to seek help for mental distress than it is for men, and more acceptable for women to use psychiatric services and medications. Further, there have
been criticisms of a tendency to medicalise and pathologise women’s reproductive health and hormones, but not that of men.

**Women with Children**

Until relatively recent times, children were regarded as the property of the husband. If the mother was seen as unfit to raise “his” children, they could be removed from her influence. Also until recently, people with mental illness could expect to spend long periods of time in institutions. Producing or raising children was not an option for women with mental illness. If a woman did become pregnant, often she would be forced to relinquish her child at birth. Being a parent was simply not an important factor in the treatment of women with mental illness.

**The Illnesses**

Mental illnesses usually involve some physical dysfunction in the brain, but many other psychosocial and environmental factors play an important part. Often, a mental illness is triggered by a stressful event. For many women, their psychiatric symptoms may be a fairly natural response to some adverse event or situation in their lives, such as violence. There are different types of mental illnesses. They are most often transient or episodic rather than continuous. Sometimes an episode of mental illness will occur only
once. Treatments vary according to the individual and the illness. However, women frequently complain that they are offered drug-based treatments only, when they require an informed choice including psychosocial management. Mental illnesses fall into two main groups: psychotic and non-psychotic. Within these groups are a number of different illnesses.

**Psychotic Illnesses**

Psychoses involve losing touch with the shared reality. People with psychoses have their own parallel or alternate reality that is exclusive to them. What they see, hear or feel will be different from what those around them experience. People with psychoses may have delusions. These are false beliefs, usually of persecution, guilt or grandeur. Their delusions or hallucinations are likely to result in a good deal of fear and confusion for the person suffering the illness, and may be difficult for those around them to cope with. Psychotic illnesses include schizophrenia and bipolar disorder. Most can be treated with medication and psychosocial therapies, so that those affected can live successfully in the community.

**Non-psychotic Illnesses**

These are largely disorders of affect, or feelings: uncontrollable or exaggerated feelings of great sadness, anxiety,
panic, depression, tension or fear. For many, these illnesses become so severe that normal day-to-day activity is a major challenge, or not possible at all. Non-psychotic problems include phobias, depression and obsessive compulsive disorder. Often, the symptoms of these illnesses are not evident to other people, but they cause great distress to those affected.

The Major Diagnostic Categories

Schizophrenia

It is an illness that causes a person to have difficulty in deciding what is real and what is not real. One in 100 Australians is diagnosed as having schizophrenia – equal numbers of men and women. There is no known cause or cure for the illness, but symptoms can be treated and controlled. Symptoms include:

• Major changes in behaviour and feelings,

• Disordered thoughts,

• Delusions,

• Hallucinations,

• Withdrawal, and

• Loss of initiative, energy and motivation.

Until recent years, people with schizophrenia could expect to spend much of their lives in hospital, as this was the only
treatment. Now, they can live at home and function in the community as long as their symptoms are controlled with medication and community support. The groups of drugs used to manage schizophrenia are called neuroleptic or anti-psychotic drugs. They include Modocate, Melleril, Serenace and Stelazine. They often have troublesome side effects which can be treated with other medications. Short periods in hospital may be necessary at times, when symptoms worsen. People can choose to go into hospital, or be referred by a doctor. However, if they become a risk to themselves or others, they may be admitted as an involuntary patient.

**Bipolar Disorder**

This illness was formerly called manic depression. It involves alternating episodes of mania (a euphoric, hyperactive state) and depression (deep sadness or emotional flatness, low motivation). Mood swings can occur over months, or as often as several times in the course of a day. Symptoms of mania include:

- Feeling uncontrollably high,
- Feeling irritable,
- Talking a lot, and very quickly,
- Fast flow of ideas,
• Not needing or wanting to sleep,
• Insensitivity to others,
• Overspending, and
• Lowered perception of danger.

Symptoms of depression are the same as for unipolar depression. Bipolar disorder can include an element of psychosis if the person experiences delusions, disordered thinking or hallucinations.

Treatment focuses on stabilizing the extremes with medication. Lithium carbonate is the most common and successful drug for stabilizing the highs and lows and controlling manic symptoms. Lithium can have a number of side effects. If the dose is too high, toxicity can occur.

**Depression**

This is thought to be the most common mental disorder, affecting an estimated one in four. Twice as many women as men are diagnosed with depression. Depression has two primary features:

• An overriding feeling of sadness, negativity, and
• Loss of interest in things previously enjoyed.
As well, people with depression experience at least three of the following symptoms:

- Loss of energy or physical agitation,
- Changed sleeping patterns,
- Changed eating habits,
- Poor concentration, difficulty making decisions,
- Feelings of guilt,
- Lowered self-esteem,
- Low motivation, and
- Not wanting to live.

It may not be obvious to others that someone is depressed, but the disorder is distressing and debilitating. It can result in suicide.

A variety of effective treatments are available. If the depression is mild-moderate, psychosocial treatments can be very successful. These include counselling, lifestyle changes leading to better self-care and reduced stress. For more severe depression, medication can lift the mood to allow effective use of psychosocial interventions. The common antidepressant drugs are Prothiaden, Aurorix, Prozac, Sinequin and Tryptonol. Antidepressants are not addictive but they often have side effects.
Psycho-neurotic Disorders

This group of problems is characterized by feelings of fear or anxiety about aspects of life that are not a problem for most people. As many as one in three people may suffer an anxiety problem. It affects twice as many women as men, and is more prevalent among the poor and the elderly. Common symptoms include:

• Jitteriness, tension,
• Feeling tired,
• Dizziness, feeling faint,
• Sweating, trembling, heart palpitations,
• Sleeplessness,
• Difficulty concentrating, and
• Hyper-vigilance.

Treatments include a variety of psychosocial interventions. Tranquilizers are the most common medication prescribed for anxiety problems, particularly the benzodiazepines which include Librium and Valium. Generalized anxiety is a pervasive feeling of fear and anxiety which is generally present, and does not relate to a specific cause.

Panic attacks are a sudden unanticipated feeling of terror and helplessness. An attack may last seconds, hours or even a few
days. People are likely to develop anticipatory anxiety – fear of having a panic attack – which can severely disrupt their lives.

Phobias are an intense fear of a specific objects or situations. People with phobias usually organize their lives to avoid the feared situation.

Obsessive-compulsive disorder is characterized by repetitive thoughts (obsessions) and acts (compulsions), such as hand washing, counting, checking and rituals. The prevalence of OCD is difficult to determine, as many people hide the problem from others. It affects equal numbers of men and women.

Women want sensitivity to gender issues. Many had been sexually assaulted, and saw their violent past experiences as central to their problems. Often they had difficulty talking to male medical staff about this issue. They want privacy and security. They want to be shown respect regardless of their state of mental health. They want confidentiality respected. They want to know who will have access to their files, and for what reason. They want information about their medications, and informed choice about treatment methods. They want to know what all the alternatives are. They want holistic health care, including their physical problems as well as their mental issues. They want continuity of
care, through long-term commitment of workers. They hate telling their story over and over again. They need to be able to build a relationship and develop trust with workers, and this takes time. They want choice about their workers, and they want workers who are honest, direct and caring.

Studies have shown that women are twice as likely to suffer from depression as men. This disparity remains constant across race and class. It is important to recognize that depression is not a sign of weakness or laziness. Depression is a very common condition. While studies on depression in the South community are lacking, experts do know that one in five Americans are affected by depression at some point in their lives.

Different factors contributing to a higher incidence of depression in women than in men include:

- Biological Factors
- Social and Cultural Factors
- Other Factors

Women are more likely to have hormonal fluctuations and imbalances throughout their lives, based on their menstrual cycles, pregnancy and menopause. Other issues related to pregnancy, such as miscarriage, unwanted pregnancy, and infertility can also
influence a woman’s susceptibility to depression. In addition, postpartum depression (link to PPD) is a specific type of depression that can occur after a woman has given birth.

**Social and Cultural Factors**

**Responsibilities:** Women are more likely to feel overwhelmed because of their family and household obligations. Particularly in the South community, women are sometimes expected to work outside of the home as well as complete all the tasks required to successfully run a household. They may not feel as if they can ask their husband or children for help, or pay someone to assist with tedious household work.

Depression is more common in women who are not able to get help with housework and childcare. Additionally, single mothers are three times more likely than married mothers to experience an episode of major depression. Women who are not single mothers but believe they are solely responsible for the household and childcare responsibilities can also be at a higher risk for depression.

**Roles:** Women who feel a relative lack of power and control over their lives in comparison to men may feel helpless. They could have a sense of being powerless because they do not have access to
educational or employment opportunities they desire. This sense of helplessness or powerlessness may lead to depression.

**Pressures:** Many women are brought up feeling they need to fulfill an impossible array of ideals simultaneously. They may expect themselves to achieve their own perfect version of multiple roles: daughter, daughter-in-law, wife, mother, friend, sister, and/or professional career woman. Intellectually, they may know that it is not possible to be perfect in all of these aspects of life, all the time; but they may still push themselves to a breaking point. Without balance, it is easy to reach a state of anxiety, stress and depression. Unfortunately, when women are anxious, stressed, or depressed, it is even more difficult to aspire to the women they want to be.

**Body Image:** Women’s concerns about body image can also lead to depression.

**Abuse:** Women are much more likely to experience abuse at the hands of an intimate partner. Any type of abuse—physical, verbal, sexual and other types—can influence chances of experiencing depression.

**Typical Stressors:** Women are often expected to occupy a number of roles at the same time: wife, mother, homemaker, employee, or
caregiver to an elderly parent. Meeting the demands of so many roles simultaneously leads to stressful situations in which choices must be prioritized. Women are often forced to choose whether to pursue or further a career versus whether to devote more time to home and family.

Many women prefer to work outside the home because it gives them a greater sense of life satisfaction. For other women, such as those who run single-parent households, employment is not an option—it is a necessity. Compared with men, women are frequently given jobs with less autonomy or creativity, which decreases their level of job satisfaction. Women may also have more difficulty being accepted in the workplace because of hierarchical structures preferring men. Documentation repeatedly shows that women's salaries are lower than those of men in comparable positions; women tend to be paid less even when performing the same job as men.

When women do choose or are required to work outside the home, they continue to perform the bulk of household duties as well. Rosenfield (1999) reported that compared to men, women perform 66% more of the domestic work, sleep one-half hour less per night, and perform an extra month of work each year. Needless
to say, increased workloads and decreased attention to rest and relaxation are stressful and pose obstacles to women's mental health.

Divorce results in more severe consequences for women who choose or are able to stay home in deference to child-rearing. Such women depend on marriage for financial security. Such domestic skills as childcare and housekeeping are not highly valued by society, and thus are poorly compensated in terms of money. Women who have never been employed and then experience divorce often have few options for securing adequate income.

Although women's ability to form meaningful relationships is a buffer against stress, it can also be a source of stress. Caring about another person can be stressful when that person is not doing well physically or emotionally. Many families take for granted that the female members will care for elderly parents who are no longer self-sufficient. As a result, many women in their forties or fifties are caught between the needs of their college-age offspring and the needs of dependent parents or parents-in-law. Interpersonal conflicts resulting from these heavy burdens may cause stress or lower self-esteem. Women may also view unsuccessful relationships as representing failure on their part to
fulfill traditional feminine qualities such as nurturance, warmth, and empathy.

Additional sources of stress common to women include victimization, assertiveness, and physical unattractiveness. Victimization is a constant concern due to the power differential between men and women. Assertiveness may be stressful for women who have had little experience in competitive situations. Physical unattractiveness may cause some women who adhere to unrealistic standards of feminine beauty to experience shame, or place them at risk for developing eating disorders. Women considered unattractive may also suffer discrimination in the workplace or in admission to higher education. In addition, the double standard of aging in contemporary society means that all women will eventually have to cope with the stigma of unattractiveness simply through growing older.

**Typical Coping Strategies**

Studies suggest that women typically react to stress by seeking social support, expressing feelings, or using distraction. These strategies might include praying, worrying, venting, getting advice, or engaging in behaviors that are not related to the problem at all (including such antisocial behaviors as drinking alcohol).
Seeking social support and distraction are considered avoidant coping strategies because they do not focus on solving or overcoming a problem, only on alleviating the stress associated with the problem. Research is inconclusive regarding whether men or women are more likely to use problem-solving, which is considered an active coping strategy.

**Typical Patterns of Psychopathology**

Women are more likely than men to experience internalizing disorders. Primary symptoms of internalizing disorders involve negative inner emotions as opposed to outward negative behavior. Depression (both mild and severe) and anxiety (generalized or "free-floating" anxiety, phobias, and panic attacks) are internalizing disorders common to women. Symptoms include sadness; a sense of loss, helplessness, or hopelessness; doubt about one's ability to handle problems; high levels of worry or nervousness; poor self-esteem; guilt, self-reproach, and self-blame; decreased energy, motivation, interest in life, or concentration; and problems with sleep or appetite.
1.13 A BRIEF PROFILE OF PSYCHIATRIC DISORDER AND PSYCHOSOCIAL DISTRESS

Psychiatric Disorders

Comparative 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, whereas substance disorders are more prevalent among men. The disability-adjusted life years data recently tabulated by the World Bank reflect these differences. 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 across the world. (Desjarlais et. al. [1995]. Explanations proposed for gender differences in psychiatric morbidity in Asia, Africa, the Middle East and Latin America echo established associations among poverty,
isolation and psychiatric morbidity for women in Western Europe and the United States (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 London. 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 sociopathy, and other mental illnesses which are highly correlated with societal breakdowns 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. Das, 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 Brazil, Mexico and Pakistan.

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, thus one can 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 through South and North America, the Mediterranean region, Africa and Asia, and in Middle Eastern societies. 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. Such findings appear in studies done in settings as diverse as Somalia, Iran, Malaysia, and among Central Americans who are refugees who fled civil strife and societal breakdown and currently live in the United States.

Poverty, domestic isolation, powerlessness (resulting, for example, from low levels of education and economic dependence), 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) also 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. 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.

It took the United Nation's "Decade for Women" to begin to make women's productive, as well as reproductive, roles visible to the world. Many development policies, and most recently in Asia, 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. Yet, the global consciousness-raising of the United Nations has spawned a number of programs that enable women to be
productive, to control their own labor, the means of production and their earnings. 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. What can be done? What has been accomplished thus far? What creative efforts may serve as models and inspiration for future action?
1.14 GENDER IDEOLOGIES AND HEALTHY POLICIES

Just as important as 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 meantime, one 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 Chinese Indonesian 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.

Building on 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 establishing baselines for women's health and well-being and measuring progress; developing ways of monitoring the impact of structural adjustment programs on women's welfare, and establishing programs to mitigate their adverse effects; enforcing or enacting legislation to improve women's status; addressing
women's need for equitable employment and economic development; and 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. International support 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.

1.15 HEALTHY POLICIES AND MENTAL HEALTH POLICIES

Health policies can be distinguished from "healthy" policies at the level of the state. 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. Although furthering gender equity in state ideologies requires the mobilization of political will and political action, as well as attention to women's voices and participation, the impact on women's well-being, and therefore the well-being of society, has been shown to be considerable.

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. Highly skilled clinicians as well as broader programs are necessary to address the deeply troubling experiences women encounter when faced with decisions about how to make use of scarce family resources or how to plan for the care of children who may be orphaned because of familial HIV.

Although 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 (and often men as well) is notoriously authoritarian in many places in the world, 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. Evaluation of training and enhancing the competence of primary care physicians and health workers to treat the consequences of domestic violence, sexual
abuse and psychological distress and mental disorders may occur in tandem with a review of what women ideally want from health caregivers.

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 as female circumcision, female infanticide, gender-specific abortion, and feeding practices that discriminate against girl children.) 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 whole society and female education is but one example. Evidence is overwhelming that the education of females is the single most important factor in improving the health of infants and children, and of men. It is even a factor in reducing alcohol consumption by husbands (which, in turn, reduces male abusive behavior). Similar analyses of links
between legal inequities (such as gender discrimination in family and criminal law) and sexual and domestic violence and their health consequences for women and their families would provide another. A third example is to emphasize the link between health and access to and control of economic resources and opportunities.

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, international agencies, and local governments. The following recommendations do not propose formulas for the development of specific solutions, but suggest ways that recognize the complexities of creating mental health policies, and ultimately, mainstreaming a gender perspective in the health sector that recognizes the concerns of the very people most affected by the problems in question.
1.16 RECOMMENDATIONS FOR SPECIFIC INITIATIVES IN MENTAL HEALTH SERVICES AND TRAINING

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. It is 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.

Yet mental health services in most societies are inadequate. Well-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. The human rights of the mentally ill are often severely compromised, and mental health care is too often associated with abusive social control. Financial investment is required for sustainable programs, and creativity is needed to build programs that join local resources with professional knowledge.

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, including rational drug policies for psychototropic medications and the reliable provision of adequate supplies at reasonable costs (selected generic antidepressants, antipsychotic and anticonvulsant drugs), must be complemented by non-medical support groups, consumer groups and healing institutions that provide crucial care in many communities.
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. And since community practitioners often depend almost exclusively on agents of pharmaceutical companies for new information on medications, initiatives in continuing education are needed to provide more basic training in the safe and effective use of psychotropic medications.

With appropriate training and supervision, nonphysician 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 training programs and shown they can be effectively employed in societies as diverse as India, the Philippines, and Tanzania. In societies in which non-physicians provide a substantial portion of primary care, specialized training activities are a cost-effective means of improving and extending mental health services.

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.

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 of their own 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. Such education also renders women less likely to tolerate domestic violence and abuse, or the spending of substantial portions of the family income on drinking or gambling by their spouses. Educated women are also more likely to be receptive to and engaged, as equal partners, in public health programs.

Women throughout the world 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. Policies may be
evaluated by women's groups not only in terms of how they support women's mental health but also in terms of the quality of services offered to women, children and men.

Encourage initiatives to attend to the causes and consequences of collective and interpersonal violence.

Collective and interpersonal violence is one of the most pressing problems in the world today. Wars, 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. Women's organizations have taken major roles in leading such efforts in the past and can be models for future efforts as well.

Curtailing and preventing interpersonal and domestic violence (often generated by community violence and breakdown) 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 require laws that make domestic violence against women (and children) a crime like Direct efforts, specific to primary prevention of mental disorders, behavioral, psychosocial and neurological disorders.

Such 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. In addition, prevention programs require an understanding of indigenous protective factors, such as the activities of caretakers of those who are ill and those local practices that enhance the mental and physical health and well-being of individuals and of communities. Listening to women, professional and lay, should help in identifying these factors.

The state of women's mental health is indeed in a state of flux. On the one hand, it has begun to figure, as never before, on the agenda of many national and international commissions and organizations. The World Health Report (1) says, "Women's health is inextricably linked to their status in society. It benefits from equality, and suffers from discrimination. Today, the status and well-being of countless millions of women worldwide remain tragically low."

UNDP has developed two measures of the disparity between men and women. The Gender Empowerment Measure (GEM) measures gender inequality in two key areas of economic and political participation and decision-making. The other GDI (Gender Related Development Index) measures achievement in life
expectancy, educational attainment and income. Based on all available data, UNDP concludes that "no society treats its women as well as its men".

Databases generated by many sources include appalling statistics on women's health in general and mental health in particular. Notable among these has been the estimate of the Global Burden of Disease, which has named unipolar depression among women to be the second most important cause of disease burden by the year 2020. The excessive preoccupation of the health care system, its planners and administrators about mortality has shifted to morbidity, well-being and quality of life, all of which are profoundly influenced by mental health.

On the other hand, reports of violence against women are on the increase, violence of a nature that scars the psyche almost permanently and even affects the social position of women adversely. Childhood sexual abuse, female infanticide in some societies, battering of female children, the resulting homelessness and psychological trauma inflicted by dowry demands on newly married women in countries such as India are all sordid tales of the world's apathy, neglect and indifference to women's woes. The relative lack of education and authority make them extremely
vulnerable to all kinds of abuse, all of which result in increasing emotional morbidity. This inextricable intertwining of the state of education, economy, autonomy and health makes it imperative that a multipronged strategy be deployed to systematically address women’s mental health problems.

**1.17 TRIUMPHS AND CHALLENGES:**

Over the past ten years, considerable attention has been focused on women's health. Women's Health Definition Women's health is the effect of gender on disease and health that encompasses a broad range of biological and psychosocial issues. Concerns, especially in the area of sexual and reproductive health. Within the framework of WHO's definition of health[1] as a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, reproductive health, or sexual health/hygiene. The women's movements--both in the area of health as well as human rights--and other organizations of civil society have collaborated to monitor the governments' fulfillment of the Cairo and Beijing agreements, recognizing women's participation in society and understanding health as a human right of all women.
Based on these commitments, the countries began to open dialogue on issues of gender, violence and sexual and reproductive health. Nonetheless, the field of mental health has remained hidden. Clearly, mental health is a requirement *sine qua non* [Latin, *Without which not.*] A description of a requisite or condition that is indispensable.

In the law of torts, a causal connection exists between a particular act and an injury when the injury would not have arisen but for personal development, economic progress, national development and, above all, human development. As a human right of all women, mental health must be incorporated as a visible part of the public health agenda. Those of us who are committed to this task face the following challenges:

- To work for the inclusion and transversalization of gender in public policies, in health policies and especially in policies related to mental health, with an emphasis on women;
- To provide information and assistance assuring that the curricula of human resources training in health and mental health include the issues of gender and violence;
- To develop indicators of gender in mental health.
The information systems diagnosing mental health statistics have focused on gathering information on suicide and self-inflicted injuries and the prevalence of some psychiatric disorders and on showing health care coverage in terms of numbers of persons treated, number of hospital beds, turnover of these beds and rates of hospitalization

- The placing of a patient in a hospital for treatment.
- The term of confinement in a hospital.

One must have information that allows us to identify the practical and strategic needs of the users of these services. This information must not only be desegregated by sex, but also we must develop gender indicators that allow us to evaluate the state of mental health, indicators that measure the use of time, domestic roles, public roles, participation in decision-making, use of financial resources, care for the family health, abuse of toxic substances, etc.

To encourage more horizontal practices in mental health so that women and men may work together to help social workers and health care professionals understand the realities of their mental health and daily life. Such actions have a long history in the treatment of mental health problems but very limited experience in
terms of promoting mental health and preventing mental illness. This effort requires practices that are linked to contextual realities: the people from the community must participate in the management of self-care and mental health.

To train primary health care and mental health care professionals to provide care that meets the practical and gender-specific needs of the communities that they serve.

It involves the different social and institutional actors in educational initiatives to overcome gender inequities. The socialization of gender based on stereotypes foments inequitable and unjust gender relations. Overcoming this reality demands interventions in the health sector and within the family and the community, such as the campaigns designed by the educational sector that draw attention to gender inequity and power relations that put women at disadvantage.

To de-medicalize daily life and provide women and men with the tools that will facilitate community empowerment and women's autonomy and participation in decision-making; To include initiatives of non-violence, solidarity and conflict negotiation at the community level. In this effort, self-help group, nonprofessional organization formed by people with a common problem or situation,
for the purpose of pooling resources, gathering information, and offering mutual support, services, or care are effective mechanisms for transformation and mental health.

1.18 RATIONALE OF THE STUDY

Mental health problems affect women and men equally, but some are more common among women. Various social factors put women at greater risk of poor mental health than men. Mentally healthy women generally talk about their feelings more than men and more often have stronger social networks of friends and family. It is particularly important that women understand how the choices are made in everyday life can affect mental health. Women are particularly exposed to some of the factors that increase the risk of poor mental health because of the role and status that they typically have in society. Therefore, the present study will help to know about the level of awareness and attitudes of the people regarding mental illness. Many researches lack in the area of knowing reason for the essential factors that create stress and mental health problems for women. Hence, there is an urgent need for taking up studies for abstracting the significant information.