CHAPTER – II

REVIEW OF RELATED LITERATURE

2.1. INTRODUCTION:

In previous chapter, background of the study in terms of women’s mental health were presented. This chapter deals with the review of related literature.

The literature in any field forms the foundations upon which all the future work will be built. If we fail to build the foundation of knowledge, provided by the review of related literature, our work is like to be shallow and naïve and will often becomes a duplicated one (Borg, 1968).

In the field of the research, the worker needs to acquire up-to-date information, about what has been thought and done in the particular areas from which one intends to take up a problem of research it helps the investigator to decide whether the evidence already available solves the problem adequately without further investigation and thereby avoid the risk of duplication.
2.2. NEED AND IMPORTANCE OF REVIEW OF RELATED LITERATURE:

NEED:

Review of Related Literature provides up-to-date information about the relevant literature, which has already been researched by others. It is considered pre-requisite actual planning conducted by the study. It provides significant information to formulate hypothesis, objectives and definitions of technical terms, selection of sampling, tools and methodology.

Review of related literature helps the researcher in selecting the review and to know the recommendation of previous researcher for further research, which were, listed in their studies.

IMPORTANCE:

1. To show whether the evidence already available solves the problem adequately without further investigation.

2. It also tells the researcher what has been done, found and accepted and what needs to be done revealing the states of research.

3. It provides ideas, theories, explanations or hypothesis valuable in formatting the problem.
4. It suggests appropriate methods of research to find the solution of the problem.

5. It suggests appropriate data gathering tools and techniques for the collection of data.

6. It locates comparative data and findings useful in interpretation of results, discussion of results and formulating conclusion.

7. It contributes to the general research competence of the investigator.

2.3 PREVIOUS STUDIES

Penkower (1988) studied Husbands' Layoff and Wives' Mental Health: A Prospective Analysis

A prospective study focused on the short-term and long-term mental health effects of husbands' layoff on wives. A sample of 149 mothers of young children, approximately half of whose husbands became unemployed due to layoff during the two-year study period, was examined. It was hypothesized that husbands' layoff would cause elevations in psychiatric symptoms and that women with particular risk factors would be more vulnerable to the impact of this event. The effects of the following eight risk factors, measured before husbands' layoff, were examined:
psychiatric history, familial psychiatric history, three or more children in the home, lack of employment outside the home, financial difficulties, low marital satisfaction, low social support from relatives, and friends. Although husbands’ layoff did not have short-term effects on wives’ symptoms, their levels of distress were elevated by the end of the study period. In addition, three risk factors—familial psychiatric history, financial difficulties, and low social support from relatives—significantly increased women’s vulnerability to long-term psychological distress following their husbands’ layoff.

Barnett (1990) studied Job Experiences Over Time, Multiple Roles, and Women’s Mental Health: A Longitudinal Study

The objectives of the study were to know the changes over time in the quality of a woman’s job associated with changes in her psychological distress. Do family roles moderate these relationships? These questions were addressed by using longitudinal data from a 2-year 3-wave study of a stratified random sample of 403 employed women who varied in occupation, race, partnership, and parental status. After estimating individual rates of change for each woman on each of the predictors and the outcome, the authors modeled the relationships between family role occupancy and change in job-
role quality on the one hand, and change in psychological distress on the other. Among single women and women without children, as job-role quality declined, levels of psychological distress increased. Among partnered women and women with children, change in job-role quality was unrelated to change in psychological distress.

Sheppard (1991) studied General Practice, Social Work, and Mental Health Sections: The Social Control of Women

A survey was undertaken of all referrals for compulsory admission received by a city mental health centre over a one year period. The centre receives the overwhelming majority of all these referrals in the city. Referrals from GPs were compared with other referrals focusing particularly on women. The results indicate GPs discriminated against women, referring considerably more women than men with less emphasis on major (psychotic) mental illness. The involvement of approved social workers (ASWs) in the assessment process was associated with diversion of many of the women away from compulsory admission, although even they appeared affected by patriarchal assumptions. GPs' behaviour with regard to sections is consistent with reports about sexist practice in other areas of work. This, however, is particularly grave with sections because
of civil liberties implications. The study concludes that ASWs need be aware of potential sexist GP practice, that their psychosocial perspective is critical to assessment and that ASW training should include gender issues.

Simonsick (1993) studied Relationship Between Husband’s Health Status and the Mental Health of Older Women

This study examines the association between husband’s health and the mental health of community-dwelling White women 65 to 75 years of age and how the wife's health, socioeconomic and social resources, and marital quality affect this relationship. Husband's health strongly predicts wife's mental health; the negative impact of which is more pronounced when the wife has poor or declining health as well. Marital quality is a strong predictor of the wives' mental health. Analyses examining the independent and joint effects of marital quality and husband's health on wife's mental health indicate that the negative association of illness in a spouse on wife's mental state is, in part, a function of the impact husband's health has on marital intimacy and shared pursuits. Of the socioeconomic and social resources examined, only availability of close friends shows a substantial relationship to the wives' mental health.
Pruchno, et.al. (1996) made a Study on the Mental Health of Aging Women with Children who are Chronically Disabled: Examination of a Two-factor Model

Data were collected from 838 women over age 50 who have either a child with a developmental disability or a child with schizophrenia. Lawton et al. (1991) parallel channel hypothesis, which suggests that positive and negative aspects of mental health have differential predictors, was tested. Results indicate that positive care giving appraisals were predicted by quality of the mother-child relationship, while negative caregiving appraisals were predicted by the amount of help mother provided to her child, mother's health, child's behaviors, and positive appraisals. Positive well-being was predicted by mother's health, positive appraisals, and negative appraisals, while negative well-being was predicted by mother's health, child's behaviors, and negative appraisals. Hence, the data support the usefulness of the hypothesized model.

Punter (1998) studied Folding Back the Shadows: A Perspective on Women's Mental Health

This study has a very antipodean perspective. Romans are a psychiatrist, firmly embedded in the medical tradition, as are several other contributors. Although the medical model slants
thought and discussion towards considerations of illness and treatment, there is due consideration given to broader historical and sociological perspectives. Biology, psychiatry and sociology are elegantly balanced. Brookes's interesting historical introduction to women's mental health includes moving stories of women incarcerated in asylums in New Zealand from their earliest days. The social influences on women's mental ill health, including the social pressures on value systems, are well articulated throughout the study. There is an interesting section on undertaking research in this area; indeed, the primary impetus for the book came out of research undertaken at the University of Otago. Qualitative research techniques are given due weight, and there is also a balanced feminist perspective on women's mental health research. For those interested in intercultural issues, Cheung writes about the relationship between acculturation and mental health. It should be noted that ‘Asian women’ in New Zealand are mostly of Chinese and Cambodian origin. The concluding chapter is written by a woman sociologist who gives a moving account of her recovery from mental illness. It is pointed out that women's disadvantaged social status is intimately linked to gender differences in mental disorders and that good social relationships are central to women's mental health. Furthermore, women have been under-
researched and all too often treatment policies are extrapolated from data collected for men. Services are often inappropriate for women, failing to recognise their need for safety from violence and the importance of maintaining their mothering and affiliation roles. Cultural differences are important in the definition and assessment of mental health problems and need to be respected and understood. Finally, mental health services must work with many other sectors, such as women's groups, welfare agencies, churches and self-help groups, to provide a coordinated approach.


This study encourages the widespread adoption of an integrated, ecological framework for understanding the origins of gender-based violence. An ecological approach to abuse conceptualizes violence as a multifaceted phenomenon grounded in an interplay among personal, situational, and sociocultural factors. Although drawing on the conceptual advances of earlier theorists, this study goes beyond their work in three significant ways. First, it uses the ecological framework as a heuristic tool to organize the existing research base into an intelligible whole. Whereas other theorists present the framework as a way to think
about violence, few have attempted to establish what factors emerge as predictive of abuse at each level of the social ecology. Second, this study integrates results from international and cross-cultural research together with findings from North American social science. And finally, the framework draws from findings related to all types of physical and sexual abuse of women to encourage a more integrated approach to theory building regarding gender-based abuse.


The study was conducted by Department of Psychology, Jai Narain Vyas University, Jodhpur to know the unique environmental stress attributes of working women in the public sector as compared to private sector and non-working women; to know the effect of family environment dimensions on the mental health of working women in both the sectors vis-à-vis non-working women; to know what are the changes in mental health status as a result of work environment factors affecting working women in public and private sector and non-working women; and to understand the level of insecurity among women in the private sector. Incidental purposive sampling technique was
used to select the sample. In the present study, 386 working and 193 non-working women were taken as the sample. Findings indicated that the feeling of insecurity, unsafety and lack of self-confidence was more among working women. Family members of working women in the public sector and non-working women were concerned and committed to family affairs, and were found supportive to each other. The family members of private working women encouraged them to be assertive, self-sufficient and to make decisions on their own. They also preferred an achievement oriented or competitive framework than their counterparts. The order and organization level was higher in the families of private women in terms of structuring family activities, financial planning and explicitness and clarity with regard to family rules and responsibilities than the families of women working under public sector and non-working group. Feelings of personal development and growth and the desire to be self-sufficient was higher among working women in the public sector. Working environment of the private sector emphasized good planning, efficiency and encouraged the worker to “get that work done”, which was different from their counterparts. Private sector working women perceive direct stresses like insecurity of jobs, excess work and less freedom due to which their emotional balance, adjustment process and tolerance level was under great
threat which influenced their mental health as compared to women working in public sector and non-working women respectively. The problems faced by private and public sector working women in India need a serious concern. Perceptible changes can definitely be brought about with sincere efforts and proper attention from all concerned. The actual situation must be brought out in the open by conducting more fact oriented studies, and researcher’s efforts can create social awareness about their problems among all. Social scientists must realize their responsibilities and work in a more coherent, practical and result oriented manner.

Abel (2001) studied Women and Mental Health

Prevalence data estimating the number of women compared with men with significant psychiatric disorder or psychological symptoms have consistently found women to have higher rates both in the UK and other Western countries. Clinicians and researchers alike are increasingly aware of gender differences and their potential effect on aetiology, presentation, course and management issues in a range of mental disorders. This multi-author book takes a closer look at depression, schizophrenia, perinatal illness, eating disorders and substance misuse and the possible effects of gender on them. It adds to the
expanding literature that seeks to address the lack of provision of appropriate services for groups with distinctive needs. Women clearly are a group of health service users with specific needs related to their place in modern society and their particular presentation of mental health problems. Therefore, any book focusing on women's mental health is welcome and this one has the advantages of being easy to read, disorder-specific for ‘quick dip’ information which is well presented. The main criticism is that one could easily get the impression that gender differences in mental illness expression and therapeutic response are, in the main, of biological, rather than biosocial origin, despite a paucity of good biological data. Although some of the differences in mental health presentation between women and men are traceable to biological gender differences, it is increasingly apparent that these are minor players in any gender effect. Attempts to modify psychiatric disorder with hormonal therapies have at best been relatively harmless, but have certainly not provided the elixir once promised. The likelihood is that hormonal or genetic gender effects are most prominent in relatively early neurodevelopment and neuronal plasticity and that oestrogens are likely to have greatest effects on physical and cognitive symptoms in women across their reproductive life.
This study contextualizes some of the more specifically focused studies in this Special Issue of 'Women and Mental Health' by reviewing general historical and political currents structuring contemporary discussions around questions of models, treatment and provision for women within British mental health services. It highlights some particularities of the current British context (in relation to other national scenes) in terms of the forms and expressions of feminist activity around mental or emotional distress. While not absolute mirrors of each other, resonances between general trends in feminist debates and organizational forms within feminist mental health work give rise to a wide spectrum of sites of intervention. It discusses some of the conditions that gave rise to these forms of (visible) feminist intervention within mental health service provision, focusing particularly on women's counselling and therapy services, and we offer an analysis of the range and conceptual tensions within which such interventions may be situated, including contested perspectives on power and empowerment. It also considers ways in which women's political activity around mental health issues is likely not to be noticed as such, given women's prototypical positions as patients and practitioners. It ends by identifying
what is seen as current challenges for feminist activism around distress and its links with the conditions of women's lives and oppression more generally, not only as instances of more general tensions and challenges within contemporary feminisms, but also as offering an arena of opportunity for broader alliance and coalition-building.

Eapen (2002) studied Mental Health of Women in Kerala

An attempt has been made in this study to emphasize the need to explore "social" factors, reflected primarily in the iniquitous gender roles and authorities, structures that perpetuate women’s subordination, for understanding the growing mental distress among women in Kerala. Much has been written about the high status of women in Kerala and their central role, historically, in its development based on the remarkable achievements in the social sectors (Jeffrey 1992). This is reflected in the highest levels of literacy and health for Kerala women among the states of India. More recent work did highlight the state’s weaker position if health indicators like morbidity, in lieu of mortality, were considered (Hiraway and Mahadevia 1996). Besides, there is growing uneasiness in equating high status thus defined and empowerment (Eapen and Kodoth 2001). The emerging contradictions in social
development, between the very high physical health indicators on the one hand and the alarming growth in female suicides, manifesting extreme mental distress on the other, lent some urgency to the study of women's mental health problem in Kerala.


This study relates to working women who are in their middle age of life. The objectives of the present work were to assess the mental health of working middle aged women; to find out the psychosocial stress in this age group; to know about the general physical problems of women; evaluate the reasons of family tension of these lady teachers; compare the mental health status of women who were in menopausal phase with those who were in post-menopausal phase; and to study whether being a woman these teachers are satisfied with their life or lead a so-called “happy life”. Data was collected on a sample of middle-aged lady school teachers of Varanasi City through interview schedules and questionnaires. About 94% subjects were Hindu and the remaining 4% were Muslims and 2% were Christians. Percentage of married subjects was 82% while 8% were unmarried. During middle age, 38% women reported fat gain;
32% tiredness and 22% weak eye sight as the major physical changes experienced. The reasons given for their mental problems were family (36%); and children’s education, employment, demands, marriage, etc (14%). Family income of 46% women was more than Rs. 20,000 p.m., whereas 32% had an income of nearly Rs. 10,000 per month. 82% women were living in nuclear families. 50% women reported their family environment as good; 36% had average family environment, and 14% had bad family environment. It is natural to expect some change in physical beauty with increasing age, and it was seen that 86% subjects had a complex about their physical beauty in middle age, while 14% had no complex about it. 84% of the women studied had mental tension at their work place, while 16% felt no mental tension. 62% subjects were underestimated by the family as well as society. Comparison between coping styles and reasons for family tension revealed that 60% subjects adopted avoidance pattern of coping against family tension; 26% had approach coping, and 14% had cognitive behavioural coping. Nearly 46% teachers did not find any change in their husband’s behaviour whereas 30% reported negative change in the behaviour and attitude of their husbands. 66% and 46% women had reported adjustment and insecure feelings at the time of their marriage. About 54% of the women were of the
opinion that menopause caused physical problems, but only 24% actually faced any physical problem during menopause. It was interesting to note that 64% of these women were not satisfied being a woman; and only 36% were satisfied as a wife, mother or daughter. Psychosocial Stress Scale showed moderate to high level of stress in 54% subjects, 18% cases had low scores. Anxiety level was found to be low in 64% cases and moderate in 32% cases. Programmed interventions like meditation, relaxation and other sensitization programs, aiming at lifestyle changes and emphasis on wellness as personal choices, will change their attitudes, behaviour, quality of life, etc. Such programme interventions will provide enhancement of positive healthy habits, reduce stress and will add quality of life to their greying years. Essential care and some preventive steps, if not taken in middle age, may result in serious problems with the onset of old age.

Lawry (2003) studied Basic Needs, Mental Health, And Women’s Health Among Internally Displaced Persons In Nyala District, South Darfur, Sudan

The objective of the study was to assess the basic needs, women’s health, and mental health burden to help the humanitarian aid community appropriate services in South
Darfur. A cross-sectional, randomized survey of IDP women, using structured questionnaires. Six of the nine IDP camps in Nyala district, South Darfur. A total of 1293 female household heads represented a total of 8643 household members. Respondent demographics, basic needs, morbidity, mental health, women’s health and human rights, opinions regarding women’s rights and roles in society were considered. The mean (±SE) age was 34 (±0.29) years. Respondents were mostly Muslim (99%) and married (79%). Seventy-eight percent had ration distributions (923/1187), 16% lacked covered shelter (200/1254), and mean water usage was 7.6L/person/day. The mean (±SE) number of pregnancies was 6 ± 0.09 (0-20). Sixty-eight percent used no birth control (861/1266), and 53% (614/1147) reported at least one unattended birth. Thirty percent (374/1238) reported joint decisions among partners on timing and spacing of children, 49% (503/1027) reported the right to refuse sex, and 43% (444/1036) felt that a man may beat his wife if she disobeys. Fifty percent (177/353) reported difficulties breastfeeding, and 84% (1043/1240) had been circumcised. The prevalence of major depression was 31% (390/1253). Women also expressed limited rights to marriage, movement, education, and access to health care. It was concluded that humanitarian aid has relieved a significant
burden of this displaced population’s basic needs; however, general health services, mental health, and women’s health needs remain largely unmet and present a formidable challenge for humanitarian agencies in Sudan’s South Darfur. The findings indicate limited sexual and reproductive rights that may negatively impact health and the already high maternal mortality rate.

Maclean (2004) studied Multiple Roles and Women's Mental Health in Canada

Research on the relationship between women’s social roles and mental health has been equivocal. Although a greater number of roles often protect mental health, certain combinations can lead to strain. The study explored the moderating affects of different role combinations on women’s mental health by examining associations with socioeconomic status and differences in women’s distress (depressive symptoms, personal stress (role strain) and chronic stress (role strain plus environmental stressors). Women with children, whether single or partnered, had a higher risk of personal stress. Distress, stress and chronic stress levels of mothers, regardless of employment, or marital status are found to be staggeringly high. Single, unemployed mothers were significantly more likely
than all other groups to experience financial stress and food insecurity. For partnered mothers, rates of personal stress and chronic stress were significantly lower among unemployed partnered mothers. Married and partnered mothers reported better mental health than their single counterparts. Lone, unemployed mothers were twice as likely to report a high level of distress compared with other groups. Lone mothers, regardless of employment status, were more likely to report high personal and chronic stress.

Kuruppuarachchi (2005) studied Domestic Violence and Female Mental Health in Developing Countries

In developing countries, where families are closely knit and cohesive, domestic violence was thought to be uncommon. However, studies of domestic violence in developing countries show a similar prevalence to that in developed countries. In Sri Lanka a survey at the out-patient department of the North Colombo Teaching Hospital in Ragama, a semi-urban area in the suburbs of Colombo, found that 40.7% of women had been abused by their partners (further information available from the authors on request). The abuse was physical as well as verbal, emotional and sexual and most women reacted in a submissive manner: 79% of those abused have stayed in their marriages for
more than 10 years. This submissive behaviour could be because Sri Lankan women usually lack the means to leave their husbands and live independently and the fact that society looks down upon such women. In a study in eastern Sri Lanka, Subramaniam and Sivayogan (2001) reported that most women, regardless of their level of education and their employment status, cited the welfare of their children as a prime reason for staying in an abusive relationship. Parental separation is considered a risk factor for poor mental health in the offspring. Therefore parents staying together in marriage may protect their children from mental health problems. However, in our study children of 31% of the victims had witnessed the abuse. It has been demonstrated that emotional abuse in childhood has a major impact on adult mental health (Edwards et al, 2003). Kumar et al found that 56% of women who had been abused had poor mental health. Since parental mental disorder has been shown to be associated with psychological problems in the offspring (Rutter, 1966), it is doubtful whether staying in an abusive marriage is beneficial for the children.
Kumar (2005) studied Domestic Violence and its Mental Health Correlates in Indian Women

Domestic spousal violence against women has far-reaching mental health implications. The aim of the study was to determine the association of domestic spousal violence with poor mental health. In a household survey of rural, urban non-slum and urban slum areas from seven sites in India, the population of women aged 15-49 years was sampled using probability proportionate to size. The Self Report Questionnaire was used to assess mental health status and a structured questionnaire elicited spousal experiences of violence. Of 9938 women surveyed, 40% reported poor mental health. Logistic regression showed that women reporting `any violence' - `slap', `hit', `kick' or `beat' (OR 2.2, 95% CI 2.0-2.5) - or `all violence' - all of the four types of physically violent behaviour (OR 3.5, 95% CI 2.94-3.51) - were at increased risk of poor mental health. Findings indicate a strong association between domestic spousal violence and poor mental health, and underscore the need for appropriate interventions.
Anand (2005) studied The Mental Health Status of South Asian Women in Britain

This study reviews the research on the mental health status of South Asian women living in UK. It reports on the findings from epidemiological studies of the prevalence of depression, suicide, parasuicide, deliberate self-harm and eating disorders in this community. Focus is on research studies that describe cultural influences on conceptualisations and expressions of distress, help seeking behaviours and alternative coping strategies. The influence of acculturation and “culture conflict” as they impact upon women's mental health is also highlighted. The review concludes by considering, first, salient cultural and religious concepts identified in studies that may facilitate understanding South Asian women's mental ill health, and second, the urgent need to develop gender, linguistic and culturally sensitive mental health services for women of South Asian origins now citizens of UK.

Dave et al. (2005) studied Mental Health and Aging : Focus on Women With Depression

The present study examined the prevalence of depression and other mental health disorders by assessing the records of psychiatric units of all the major private and public hospitals
and private practitioners in six major cities of Gujarat, namely Vadodara, Ahmedabad, Bhavnagar, Rajkot, Jamnagar and Surat. It also assessed the nutritional, psychosocial and cultural aspects of the population. 24 hour dietary recall method was used to assess nutritional intake, and anthropometric measurements were used to assess nutritional status. Women above 40 years of age who had a moderate degree of depression, were interviewed. The number of men who availed mental health services was higher than that of women, both retrospectively (56% men; 44% women) and prospectively (54.5% men; 44% women), except for the prospective data in Jamnagar, where the number of women was slightly higher than that of men. The most prevalent disorders were depression (50%), schizophrenia (60%), bipolar disorder and anxiety disorders (0.8%). The cases of depression were high in Surat (retrospective (32.2%; prospective 34.3%), Ahmedabad (retrospective 30.6%; prospective 25.3%), Vadodara (22.5%), Bhavnagar (22.2%) and Rajkot (21.5%). In Bhavnagar, the percentage of depression was 27.3% in retrospective data and 17% in prospective data. In Rajkot, depression was 29% prospective data and 13.9% in retrospective data. Depression was highest in the age group 61-75 years (33.4%), followed by the age group 41-60 years (31%). Menopausal and associated changes explain the higher
prevalence of depression in women in the age group of 41-60 years. Across the six major cities, schizophrenia ranked first among all mental disorders - in Vadodara (retrospective 34.1%; prospective 30.7%) and Jamnagar (retrospective and prospective 19.1% each. The study found that depressed women had a history of alcohol dependence. Only 4.62% had minimal depression, 11.29% women had mild depression, and 18.18% women had severe depression. Least nutrient intake was seen among low income women above 60 years of age. Further, younger depressed women from the middle income group showed a higher significant difference (p<0.05) and better nutrient intake with respect to energy, iron, folic acid and amino acids compared to older depressed women of the same income group. Findings also revealed significant difference (p<0.05) with poor intake of folic acid, selenium, vitamin B6 and B12. The study also revealed that the prevalence of major health problems was higher in middle income women. Locomotor problems ranked first (52%) in all the income groups, followed by oral cavity problems (43.3%) and cardiovascular problems (31%) in middle income women above 60 years of age. Nearly 33% depressed high income women aged 40-60 years reported respiratory and gastrointestinal (23.3%) problems. Over half the women with depression in the 40-60 years age group, from both
low and middle income groups, were still menstruating, while 60% of their counterparts in the high income group were not menstruating. Complaints like ‘backache’, change in vision, pain in joints and limbs, slight memory loss and dizziness were reported mainly by women above 60 years of age which could be associated with ageing. The most commonly reported psychological symptoms reported by 60-80 of the depressed women were ‘feeling tired’, ‘irritation’ and ‘depression’, ‘loss of interest in most things’, ‘isolation’, and ‘nervousness’, which were reported by half the women. The study concluded that depression is not a disease but a serious illness with biological, psychological and social aspects relevant to its cause, symptoms and treatment. The study recommended that research is needed in the use of herbal medicines for the treatment of depression that could show pronounced benefit in improving the health status.

Blehar (2006) Women’s Mental Health Research: The Emergence of a Biomedical Field

This study surveys the field of women's mental health, with particular emphasis on its evolution into a distinct area of biomedical research. The field employs a biomedical disease model but it also emphasizes social and cultural influences on
health outcomes. In recent years, its scope has expanded beyond studies of disorders occurring in women at times of reproductive transitions and it now encompasses a broader study of sex and gender differences. Historical and conceptual influences on the field are discussed. The review also surveys gender differences in the prevalence and clinical manifestations of mental disorders. Epidemiological findings have provided a rich resource for theory development, but without research tools to test theories adequately; findings of gender differences have begged the question of their biological, social, and cultural origins. Clinical depression is used to exemplify the usefulness of a sex/ gender perspective in understanding mental illness; and major theories proposed to account for gender differences are critically evaluated. The National Institutes of Health (NIH) is the primary federal funding source for biomedical women's mental health research. The review surveys areas of emphasis in women's mental health research at the NIH as well as some collaborative activities that represent efforts to translate research findings into the public health and services arenas. As new analytic methods become available, it is anticipated that a more fundamental understanding of the biological and behavioral mechanisms underlying sex and gender differences in mental illness will emerge. Nonetheless, it is also likely that integration of findings
predicated on different conceptual models of the nature and causes of mental illness will remain a challenge. These issues are discussed with reference to their impact on the field of women's mental health research.

Tam (2006) studied The Link Between Homeless Women's Mental Health and Service System Use

With high rates of psychiatric and substance use problems, homeless women need a wide variety of services. This study, focusing on homeless women with and without symptoms of mental illness, examined the association of predisposing, enabling, and need factors (based on Aday-Andersen’s health services utilization model) with use of behavioral, medical, and human services. Data from 738 homeless women from the National Survey of Homeless Assistance Providers and Clients were analyzed. Homeless women with symptoms of mental illness showed higher rates of service use in behavioral, medical, and human domains, a finding indicates that there are stronger service linkages for this group than for women without symptoms of mental illness. Predictors associated with service use differed by psychiatric symptoms among homeless women: predisposing and enabling factors influenced service use among homeless women without symptoms of mental illness, whereas
need factors influenced service use among women with symptoms of mental illness. Mental illness symptoms may be a trigger for receiving an array of services for homeless women once they gain entrance into a service system. There was a negative association between symptoms of mental illness and use of behavioral health services among homeless mothers, which may be the result of the fear of child welfare service intervention and loss of child custody. This service distribution inequity among homeless women using mental health services deserves attention by policy makers, researchers, and providers.

Ozkan (2006) studied Mental Health Aspects of Turkish Women from Polygamous Versus Monogamous Families

The purpose of this study was to determine the extent of the relationship between psychiatric disorder and polygamous marriage. The mental status of 42 senior and 46 junior wives from polygamous marriages and 50 wives from monogamous marriages was evaluated using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) and Somato-form Dissociation Questionnaire (SDQ). There was a statistically significant difference among senior, junior and monogamous wives in terms of the prevalence of somatization disorder. The prevalence of somatization disorder was the highest in
polygamous senior wives. The mean total SDQ scores differed significantly among the three groups. It was the highest in senior wives. It is clear that the participants from polygamous families, especially senior wives, reported more psychological distress. It is essential to increase awareness of the significance of polygamous family structures among psychiatrists and other therapists.

Siegel (2006) studied Impact of Husbands' Involuntary Job Loss on Wives' Mental Health, Among Older Adults

This study estimates the consequences of older husbands' involuntary job loss for their wives' mental health. Using longitudinal data from the 1992, 1994, and 1996 waves of the Health and Retirement Study, multivariate regression models were estimated to measure the impact of older husbands' involuntary job loss on wives' mental health. Authors created two longitudinal data sets of two waves each to use in the analysis. The first data set, or period, combined Waves 1 and 2 of the Health and Retirement Study and described the 1992–1994 experience of spouse pairs in our sample. It included the wives of 55 husbands who experienced involuntary job loss between these survey dates and a comparison group of wives of 730 continuously employed husbands. The second data set
described the 1994–1996 experience of couples. In particular, it included the wives of an additional 38 husbands who were displaced from their jobs between Waves 2 and 3, and a comparison group of wives of 425 husbands who were continuously employed from 1994 to 1996. Husbands' involuntary job loss, did not have any significant affect on wives' mental health. It was found that there was found no evidence that changes in husbands' depressive symptoms modified the effect of his job loss on wives' mental health. In the first period only, the effect of husbands' job loss on wives' mental health was more pronounced for wives who were more financially satisfied at baseline. There is limited evidence among this cohort that husbands' job loss increases wives' subsequent depressive symptoms. However, the effect of husbands' job loss on wives' mental health appears to be magnified when wives report being financially satisfied pre-job loss. This suggests that, for subgroups of older couples, mental health services specifically targeted at displaced men should also be made available to wives.

Kulkarni (2006) studied Women’s Mental Health: An Overview

Women often have different outcomes and experiences with mental illness compared to men. However, there is still a
‘gender-blind’ approach to the understanding and development of new treatments for mental illness. The emphasis is on: women and schizophrenia, depression in women and existing sex differences in anxiety disorders (including phobias, agoraphobia, panic disorder, generalized anxiety disorder and post-traumatic stress disorder). Utilizing gender differences in the onset, course and outcomes of mental illness may enable a better development of best outcomes for women with mental illness.

Kastrup (2006) studied War and Women’s Mental Health

The study deals with the important interactions between war, the consequences for the mental health of the women involved and the gender specific aspects of treatment hereof. War is increasingly touching civilians, and has consequences for the health of all involved, but many aspects of war affect the health of women disproportionately. Thus, wars have brought immense sexual violence and pervasive social changes into the lives of women (Arcel and Kastrup, 2004). Life is often marked by loss of family members, of social network, and of social position due to for example widowhood or unemployment. Together with the economic effects of war and the difficult access to basic supplies, this places women in a vulnerable social position. It is a fact that violence in wartime permeates the entire society but – and this is
particularly the case in patriarchal societies - as long as women are true to their gender roles they are seen as valuable, performing functions as nurses, wives, mothers or prostitutes. Due to the absence of men who are at war, or killed, the female gender role changes as women get greater responsibility as breadwinners. In such situations women may develop a new autonomy and new skills

Kermode (2007) studied Empowerment of Women and Mental Health Promotion: A Qualitative Study in Rural Maharashtra, India

The global burden of mental illness is high and opportunities for promoting mental health are neglected in most parts of the world. Many people affected by mental illness live in developing countries, where treatment and care options are limited. In this context, primary health care (PHC) programs can indirectly promote mental health by addressing its determinants that is by enhancing social unity, minimizing discrimination and generating income opportunities. The objectives of this study were to: 1. Describe concepts of mental health and beliefs about determinants of mental health and illness among women involved with a PHC project in rural Maharashtra, India; 2. Identify perceived mental health problems in this community,
specifically depression, suicide and violence, their perceived causes, and existing and potential community strategies to respond to them and; 3. Investigate the impact of the PHC program on individual and community factors associated with mental health. The study undertook qualitative in-depth interviews with 32 women associated with the PHC project regarding: their concepts of mental health and its determinants; suicide, depression and violence; and the perceived impact of the PHC project on the determinants of mental health. The interviews were taped, transcribed, translated and thematically analysed. Mental health and illness were understood by these women to be the product of cultural and socio-economic factors. Mental health was commonly conceptualised as an absence of stress and the commonest stressors were conflict with husbands and mother-in-laws, domestic violence and poverty. Links between empowerment of women through income generation and education, reduction of discrimination based on caste and sex, and promotion of individual and community mental health were recognised. However, mental health problems such as suicide and violence were well-described by participants. While it is essential that affordable, accessible, appropriate treatments and systems of referral and care are available for people with mental illness in developing country settings, the promotion of mental
health by addressing its determinants is another potential strategy for reducing the burden of mental illness for individuals and communities in these settings.


Families in remote mining towns constitute a specific sociological group living under unique geographical and socio-cultural circumstances. Isolation from friends and relatives and limited resources and opportunities for family members of mine workers are some of the distinct disadvantages of these towns. Decades ago it was observed that a large number of women in new and remote mining towns suffered from neurotic problems. In contemporary times there is a deficit of knowledge about the mental health of women in remote mining towns. However, there are certain indicators of significant mental distress among women living in these particular environments. Deriving from a review of literature, this paper explores various mining work-related issues and socio-cultural settings and processes within remote mining towns that could possibly exert coercive pressures on the psychological health of female partners of mine workers and their relationship well-being. The study suggests
that work schedules and preponderance of men in mining jobs help promote a patriarchal culture within the community and the family; thereby marginalizing women to a secondary status. Limited opportunities and resources within the community isolate women to domestic lives; while atypical work rosters associated with mining employment could negatively impact on the relationship well-being of couples. The study recommends that an inquiry into psychiatric well-being among women of remote mining communities needs to consider the socio-cultural structure and processes within these communities, and the structural nature of the mining job that could be responsible for role strain-induced stress and mental health problems among these women.

Patel (2008) studied Risk Factors for Common Mental Disorders in Women

The determinants of common mental disorders in women have not been described in longitudinal studies from a low-income country. Population-based cohort study of 2494 women aged 18 to 50 years, in India. The Revised Clinical Interview Schedule was used for the detection of common mental disorders. There were 39 incident cases of common mental disorder in 2166 participants eligible for analysis (12-month rate
1.8%, 95% CI 1.3–2.4%). The following baseline factors were independently associated with the risk for common mental disorder: poverty (low income and having difficulty making ends meet); being married as compared with being single; use of tobacco; experiencing abnormal vaginal discharge; reporting a chronic physical illness; and having higher psychological symptom scores at baseline. Programmes to reduce the burden of common mental disorder in women should target poorer women, women with chronic physical illness and who have gynecological symptoms, and women who use tobacco.

Michael (2008) studied A Contextual Analysis of Women Prisoners' Mental Health

Interviews and surveys of a sample of women in the British prison system and women incarcerated in the California prison system are used to explore differences in prisoner's self-reported mental health. Despite smaller prisons and a more prisoner-oriented environment in Britain as opposed to California, the reported rates of self-harm and mental distress are higher in Britain than California. Study examines whether these differences reflect (1) the effects of the prisons themselves; (2) differences in the characteristics and mental health histories of the women in these prisons; or (3) the interaction of the
site/prison and the characteristics of the women (contingent effects). This study statistically decomposes these data to determine what proportion of any observed differences is due to each of these components (the prison itself, the types of women housed in particular prisons, or a combination of these two factors). While these statistical data help us determine some of the correlates of mental distress among women prisoners, they are more limited for developing an understanding of how particular experiences shape women’s reactions to imprisonment. As a result, study supplements the empirical findings with narratives recorded in the interviews conducted with women prisoners in both California and Britain.

Jennifer (2008) studied Mental Health Strategies for Federally Sentenced Women in Canada: Moving Towards Community-Based Alternatives

This study provides a review and critique of mental health strategies for federally sentenced women in Canada. The context is set with a brief historical account of women’s imprisonment in Canada. In addition, the study presents a portrait of women imprisoned in the Canadian federal correctional system, including current statistical information related to admissions, type of offenses, length of sentences, classifications, age, race,
marital status, experiences of violence, mental health, as well as educational attainment. More specifically, current statistical information related to admissions, type of offenses, length of sentences, classifications, age, race, marital status, experiences of violence, mental health, as well as educational attainment is presented. A description of the treatment models currently employed by Correctional Services Canada is given and implications of the mental health treatment models, such as Dialectical Behavior Therapy and Psychosocial Rehabilitation, are highlighted. In an effort to expand on current treatment practices, suggestions are made for adopting community-based interventions and programming as an alternative to treating women with mental health issues within a prison setting.

Khodarahimi (2009) studied Women’s Mental Health In The North Of Fars, Iran

The purpose of present study was to examine the effects of demographical factors in women’s mental health in an Iranian sample. The effects of demographical factors on women’s psychopathology within a survey design investigated among 200 women who were selected by random sampling method and their mental health measured by SCL-90-R checklist. All of psychopathological indices were significantly higher among
singles, 36--40 years aged group and females with low socio economic status. Women’s levels of education and city of residence were effective on their mental health. Overall findings support of marital status, age, socio economic status, level of education and city of residence influences on women’s mental health. The common trend for demographical factors effects in women’s mental health was consistent with ones in feminine psychopathology throughout the universe but there is another cultural-bounded explanation too.


Women without intellectual disabilities are more likely to develop mental health problems as a result of physiological functioning and psychosocial risk factors. However, little is known about the mental health of women with intellectual disabilities. The aim of this study was to explore a small group of women’s perceptions of the risk and protective factors pertaining to their mental health conditions. Twelve semi-structured interviews were conducted in 2007 in Northern Ireland. Thematic content analysis identified three risk factors and four protective/resilient factors. None of the women identified
physiological functioning as a risk factor. Results suggest that women with intellectual disabilities experience psychosocial risk factors similar to those reported by women without intellectual disability. Additional risk factors place them at higher risk of developing mental health problems. However, more research is required.

Fawcett (2009) studied Mental Health and Older Women: The Challenges for Social Perspectives and Community Capacity Building

Older women tend to be either rendered invisible in relation to considerations of mental health or, conversely, constructed as potential mental health problems. In this study, attention is drawn to the position of older women with regard to current debates in the mental health field. It is argued that, within the UK and Australia, the prioritization of the management of risk and what an older woman cannot do rather than what she can adversely affects not only her mental well-being, but also the contribution that she can make to the community in which she lives. It is argued that the fostering of strengths-based community capacity building, which includes proactive, innovative and flexible underpinning practice principles, has the capacity to expand rather than reduce horizons for older women,
to confront restrictive and discriminatory barriers and to enhance quality-of-life factors.

Rao (2009) studied Community Based Mental Health Intervention for Underprivileged Women in Rural India: An Experiential Report

The objective of the study was to share experiences from an ongoing project that integrates a mental health intervention within a developmental framework of microcredit self-help groups for economically underprivileged women in rural India. The mental health intervention had two components: group counseling and stress management. The former comprised mainly of ventilation and reassurance and the latter strengthening of coping skills and the practice of a breathing-based relaxation technique. Focus group discussions were used to understand women’s perception of how microcredit economic activity and the mental health intervention had affected their lives. Women who had participated in the mental health intervention reported reduction in psychological distress and bodily aches and pains. Majority (86%) reported that the quality of their sleep had improved with regular practice of relaxation. Women unanimously stated that sharing their problems in the group had helped them to unburden. The social support
extended by the members to each other, made them feel that they were not alone and could face any life situation. The study provided qualitative evidence that adding the mental health intervention to the ongoing economic activity had made a positive difference in the lives of the women. Addressing mental health concerns along with livelihood initiatives can help to enhance both economic and social capital in rural poor women.

Nayak (2010) studied Partner Alcohol Use, Violence and Women’s Mental Health: Population-based Survey in India

The relationship between partner alcohol use and violence as risk factors for poor mental health in women is unclear. The aim of the study was to describe partner-related and other psychosocial risk factors for common mental disorders in women and examine interrelationships between these factors. Data are 821 women aged between 18–49 years from a larger collected from population study in north Goa, India. Logistic regression models evaluated the risks for women’s common mental disorders and tested for mediation effects in the relationship between partner alcohol use and these disorders. Excessive partner alcohol use increased the risk for common mental disorders two- to threefold. Partner violence and alcohol-related problems each partially mediated the association between
partner excessive alcohol use and these mental disorders. Women’s own violence-related attitudes were also independently associated with them. Partner alcohol use, partner violence and women’s violence-related attitudes must be addressed to prevent and treat common mental disorders in women.

Savas (2010) studied The Relationship Between Women’s Mental Health and Domestic Violence in Semirural Areas: A Study in Turkey

The study examines the relationship between emotional disorders and domestic violence (DV) in 395 women of different ethnicities in Turkey. PRIME MD (Primary Care Evaluation of Mental Disorders) was used for diagnosis. This is a cross-sectional and epidemiological research. Results showed that the prevalence of emotional disorders, anxiety, and somatoform disorders was 22.8%, 24.8%, and 16.9%, respectively. The mean DV score was 2.98 ± 1.32 over 10.00. DV scores were higher when women did not want to get married or did not have their family’s blessing for marriage. Observed scores were also high for civil marriage cases, or when women had a job, had low income, or were afraid of their husbands (P < .05). The number of comorbid diagnoses increased with increase in DV scores (P < .001). Mean DV scores were higher for women diagnosed with
major depression, partial remission or recurrence of major depression, panic disorder, and common anxiety (P < .05). The authors recommend that if physicians suspect any emotional disorders in women in primary care, they should evaluate for DV.

Clarke (2010) studied Psychopharmacologic Management Of Women With Common Mental Health Problems

This study reviews the essential aspects of the psychopharmacologic management of women with mental health problems, with particular emphasis on the role of the nurse-midwife as a primary care provider. The study also addresses the neurobiology of psychopharmacology, pharmakinetics, and the selection of pharmacologic treatments used for depression, bipolar disorders, anxiety disorders, eating disorders, and psychosis. Considerations for the timely and appropriate referral for psychiatric intervention for women with psychiatric or pharmacologic emergencies are discussed, and issues relating to pregnancy, lactation, and reproductive health are included. The importance of the nurse-midwife's role in ensuring women's access to and compliance with psychopharmacologic therapy is emphasized.

Court liaison services aim to reduce mental illness in prison through early treatment and/or diversion into care of defendants negotiating their court proceedings. However, liaison services may inadvertently contribute to gender inequalities in mental health in the prison system because women often do not access liaison services. This is attributed to services failing to recognize that women have different needs from men. To address this, it is essential that the needs of women in contact with the criminal justice system (CJS) are clearly articulated. However, there is a dearth of research that considers women’s needs at this stage of their journey through the CJS. This study aims to identify these needs before women enter prison. It does so through an analysis of a pilot Women’s Support Service based at a magistrates’ court, a response to concerns that women were not accessing the local liaison service. Proformas were completed by a women’s specialist worker for 86 women defendants assessed over four months. Information was collected on characteristics including education, domestic violence, accommodation, physical and mental health. This specialist worker recorded the range of needs identified by defendants at
assessment and the services to which women were referred. Access to the Women’s Support Service is high, with only 11.3% of women refusing to use the service. Women attending have high levels of physical and mental health issues. Their mental health issues have not been addressed prior to accessing the service. Women often come from single households and environments high in domestic abuse. Women have multiple needs related to benefits, finance, housing, domestic abuse, education and career guidance. These are more frequent than those that explicitly link to mental health. The Women’s Support Service is accessed by a higher number of women, many more than access the local liaison service. It is suggested that this is due to their multiple and gender-specific needs being adequately addressed by the former service and the organizations to which they are referred. Mental health needs may also be secondary to other more basic needs, which makes the generic service provided by the Women’s Support Service more appropriate than a liaison service that deals with mental health support alone.
Mond (2011) studied Mental Health Impairment in Underweight Women: Do Body Dissatisfaction and Eating-Disordered Behavior Play a Role?

The investigator sought to evaluate the hypothesis that mental health impairment in underweight women, where this occurs, is due to an association between low body weight and elevated levels of body dissatisfaction and/or eating-disordered behaviour. Subgroups of underweight and normal-weight women recruited from a large, general population sample were compared on measures of body dissatisfaction, eating-disordered behaviour and mental health. Underweight women had significantly greater impairment in mental health than normal-weight women, even after controlling for between-group differences in demographic characteristics and physical health. However, there was no evidence that higher levels of body dissatisfaction or eating-disordered behaviour accounted for this difference. Rather, underweight women had significantly lower levels of body dissatisfaction and eating-disordered behaviour than normal-weight women. The findings suggest that mental health impairment in underweight women, where this occurs, is unlikely to be due to higher levels of body dissatisfaction or eating-disordered behaviour. Rather, lower levels of body dissatisfaction and eating-disordered behaviour among
underweight women may counterbalance, to some extent, impairment due to other factors.

Baer (2011) studied Women in Combat: Consequences for Mental Health and Well-Being

The role of contemporary women in the United States military has expanded significantly. Although women remain barred from combat-related positions (Dongean, 1996), the role changes and expansion of involvement, combined with the guerilla nature of modern warfare increase their probability of exposure to combat violence and trauma. While there have been few scholarly studies on the effects of these changes on women’s mental health, there are prevalence data indicating that 71% of women present during an air or ground war experienced at least 1 combat exposure, (Carney, et al., 2003). Given the probable significance of these events to women’s mental health and overall well-being, more research is warranted. Although some work has been conducted on PTSD (Tanielian et al, 2008) it is clear that combat exposure may be associated with a variety of negative mental health effects beyond the PTSD sequelae. The purpose of this study was to explore the mental health profiles of a group of women who have recently served in the military. Data were from WAVE IV survey (follow-up 2008) of The National Longitudinal
Study of Adolescence (ADD Health), a nationally representative sample of youth (N = 15,701). Respondents were 24 to 32 years of age, and included a subpopulation of individuals who had served in the military (n = 1,112; F = 231, M=881). Analyses were conducted using Stata 11 employing appropriate weights and complex survey design adjustments. The findings showed that men had far more combat assignments (191/44). Only 5 women in the sample reported killing or believing they had killed someone. There were no significant differences between men and women in exposure to seeing someone dead or wounded (risk ratio 1.02, risk difference .02), seeing the enemy dead (risk ratio 1.03, risk difference .02), or seeing civilian dead (risk ratio 1.03, risk difference .03). Out of 27 mental health indicators, the significant items for women who have experienced combat broke into 3 subsets: Women who had low self-esteem had greater risk for combat engagement (risk ratio 1.61, t=1.96, p,.05). They reported less life satisfaction before joining the military (risk ratio 2.38, t=2.85, p<.005), and they were less likely to enjoy life upon return (.190, t=-3.74, p<.000,) Women with moderate self-esteem had risk of depression upon return (risk ratio .318, t=-3.25, p<.001) Women with high-self esteem had greater risk of combat engagement (risk ratio 1.5, t=3.41, p<.000). They had greater risk for feeling isolated upon return (risk ratio 1.35,
t=2.03, p<.04) as well as greater risk for depression (risk ratio .396, t=-4.18, p<.000). Implications: There is heterogeneity in our results which is notable for clinicians. Moreover, the findings suggest that history of mental health problems should be included in assessment. While female veterans may have more difficulty with combat trauma as reported in PTSD studies (Tanielian et al, 2008), there may be confounding variables, such as previous or additional trauma that result in negative mental health. In general, women are more likely to recognize and report mental health problems than men.

Niaz (2011) studied Women’s Mental Health in Pakistan

In Pakistan, societal attitudes and norms, as well as cultural practices (Karo Kari, exchange marriages, dowry, etc.), play a vital role in women’s mental health. The religious and ethnic conflicts, along with the dehumanizing attitudes towards women, the extended family system, role of in-laws in daily lives of women, represent major issues and stressors. Such practices in Pakistan have created the extreme marginalisation of women in numerous spheres of life, which has had an adverse psychological impact. Violence against women has become one of the acceptable means whereby men exercise their culturally constructed right to control women. Still, compared to other
South Asian countries, Pakistani women are relatively better off than their counterparts.

Greer (2011) studied Coping Strategies as Moderators of the Relation Between Individual Race-Related Stress and Mental Health Symptoms for African American Women

The purpose of this investigation was to examine coping strategies as moderators of the relationship between individual race-related stress and mental health symptoms among a sample of 128 African American women. Coping strategies refer to efforts used to resolve problems and those used to manage, endure, or alleviate distress. Culture-specific strategies were examined in the current study (i.e., efforts that are commonly used by members of a cultural group). Culture-specific efforts were hypothesized to influence the severity of psychological symptoms associated with individual race-related stress, such that frequent use of culture-specific efforts would lessen the strength of the relationship between race-related stress and psychological symptoms. Moderated hierarchical regression analyses revealed that high use of ritual-centered strategies to address race-related stress was related to severe anxiety and interpersonal sensitivity. No moderating effect of coping strategies was found for depression, obsessive-compulsion, and
somatization symptoms. The findings suggest that African American women may inadvertently utilize coping efforts that serve to increase the severity of psychological symptoms related to individual race-related stress. Mental health professionals should explore underlying emotions related to coping efforts utilized to address race-related stress among African American women.

2.4 CONCLUSION

The review of related literature helped the investigator in many ways. Some studies gave an idea to the present study. These review of related literature showed the investigator that there are very few study related to women and mental health in India and also the ways to reach the objectives of the study.