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# Women and Mental Health in India: An Overview

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## *Abstract*

*Gender is a critical determinant of mental health and mental illness. The patterns of psychological distress and psychiatric disorder among women are different from those seen among men. Women have a higher mean level of internalizing disorders while men show a higher mean level of externalizing disorders. Gender differences occur particularly in the rates of common mental disorders wherein women predominate. Differences between genders have been reported in the age of onset of symptoms, clinical features, frequency of psychotic symptoms, course, social adjustment, and long-term outcome of severe mental disorders. Women who abuse alcohol or drugs are more likely to attribute their drinking to a traumatic event or a stressor and are more likely to have been sexually or physically abused than other women. Girls from nuclear families and women married at a very young age are at a higher risk for attempted suicide and self-harm. Social factors and gender specific factors determine the prevalence and course of mental disorders in female sufferers. Low attendance in hospital settings is partly explained by the lack of availability of resources for women. Around two-thirds of married women in India were victims of domestic violence. Concerted efforts at social, political, economic, and legal levels can bring change in the lives of Indian women and contribute to the improvement of the mental health of these women.*

***Keywords:*** *Common mental disorder, disorder, domestic violence, mental health, substance abuse, suicide, women*

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## I. INTRODUCTION

Women and men are different not only in their obvious physical attributes, but also in their psychological makeup. There are actual differences in the way women's and men's brains are structured and "wired" and in the way they process information and react to events and stimuli. Women and men differ in the way they communicate, deal in relationships, express their feelings, and react to stress. Thus, the gender differences are based in physical, physiological, and psychological attributes..

Gender roles have been culturally prescribed through the prehistoric cultures to the more civilized societies. In hunter-gatherer societies, women were generally the gatherers of plant foods, small animal foods, fish, and learned to use dairy products while men hunted meat from large animals. In more recent history, the gender roles of women have changed greatly. Traditionally, middle-class women are typically involved in domestic

tasks emphasizing child care. For poorer women, economic necessity compels them to seek employment outside the home. The occupations that are available to them are; however, lower in pay than those available to men leading to exploitation. Gradually, there has been a change in the availability of employment to more respectable office jobs where more education is demanded. the differences between men and women have been socially defined and distorted through a lens of sexism in which men assumed superiority over women and maintained it through domination. This has led to underestimating the role a woman plays in the dyad of human existence.

## II. EXPERIMENTAL METHODOLOGY

### *What needs to be done?*

It is therefore, amply clear that women's mental health cannot be considered in isolation from social, political, and economic issues. A woman's health must incorporate mental and physical health across the life cycle and should reach beyond the narrow perspective of reproductive and maternal health, which is often the focus of our policies.

In the discussion of the determinants of poor mental health of women, the focus needs to be shifted from individual and "lifestyle" risk factors to the recognition of the broader, social, economic, and legal factors that affect women's lives. It is essential to recognize how the sociocultural, economic, legal, infrastructural, and environmental factors that affect women's mental health are configured in the given community setting.

If the efforts to promote women's mental health focus solely on the reduction of individual "lifestyle" risk factors, they may neglect the very factors that bring that lifestyle into being. Moreover, if the individual factors are focused in isolation, ignoring the sociocultural factors, there is an additional risk of placing the responsibility of change on the women alone. However, the truth is that largely the change is beyond their control and lies in the bigger social change. Inadvertently, the failure to change and improvise the mental health may be misattributed to the women.

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Education, training, and interventions targeting the social and physical environment are crucial for addressing women's mental health. Identification of significant persons in government departments and other relevant groups in the community, to obtain and document data indicating the extent of women's problems and the burden associated with women's mental problems and the development of policies to protect and promote women's mental health are extremely crucial.

In summary, concerted efforts at social, political, economic, and legal levels can bring change in the lives of Indian women and contribute to the improvement of the mental health of these women

## III. RESULT AND DISCUSSION

### *Mental health and mental disorders*

Mental health is a term used to describe either a level of cognitive or emotional well-being or an absence of a mental disorder. From perspectives of the discipline of positive psychology or holism, mental health may include an individual's ability to enjoy life and procure a balance between life activities and efforts to achieve psychological resilience. On the other hand, a mental disorder or mental illness is an involuntary psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture.

### *Women's Mental Health: The Facts (World health organization report, 2001)[2]*

Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men. Leading mental health problems of the elderly are depression, organic brain syndromes, and dementias. A majority are women. An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters, and displacement are women and children Lifetime prevalence rate of violence against women ranges from 16% to 50% At least one in five women suffers rape or attempted rape in their lifetime.

### *Common mental disorders*

Gender differences occur particularly in the rates of common mental disorders (CMDs)-depression, anxiety, and somatic complaints wherein women predominate. Unipolar depression, which is predicted to be the second leading cause of global disability burden by 2020, is twice as common in women. Furthermore, the lifetime risk of anxiety disorders (e.g., generalized anxiety disorder) is 2–3 times higher in females as compared to males. Moreover, depression is not only the most common women's mental health problem, but may be more persistent in women than man. During their lifetimes, females are faced with various life stressors including childbirth and maternal roles, caring and nurturing the old and sick of the family. In addition, women are less empowered due to lesser opportunities of education and respectable employment. Moreover, even those who are financially secure fear to cross social lines and therefore too are apparently vulnerable.

### *Severe Mental Illness*

Although severe mental disorders such as schizophrenia and bipolar disorders are less prevalent than CMD, the chronic course and associated disability make these disorders severe. In addition, the stigma associated with these illnesses has a major impact not only on the sufferer but also on the families. Also, the families are burdened with the care of these patients for almost their entire lives in a great number of cases. Needless to say, the emotional and financial strain on the caregivers may be overwhelming. There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect <2% of the population, females have a later age of onset of schizophrenia as compared to that in males.

## IV. SUICIDE

Studies of suicide and deliberate self-harm have revealed a universally common trend of more female attempters and more male completers of suicide. However, in contrast to the data from many other countries, except China, which records the highest female suicide rate, women outnumber men in completed suicides in India, although the gap between them is narrow. Biswas et al. found that girls from nuclear families and women married at a very young age to be at a higher risk for attempted suicide and self-harm. The suicide rate by age for India reveals that the suicide rates peak for both men and women between the age 18 and 29 while in the age group 10–17, the rate for the female exceeded the male figure. In his seminal studies, Emile Durkheim had vividly demonstrated over a century ago, that socio-cultural factors are significant determinants of suicide behavior and perhaps these impact men and women differently. In an Indian study, the 1-year incidence of attempted suicide was 0.8%, and seven of these women (37%) had baseline CMDs. CMD, exposure to violence, and recent hunger were the strongest predictors of the incident attempted suicide cases. The precipitants for suicide, according to Indian government statistics, among women compared to men are as follows: Dowry disputes (2.9% versus 0.2%); love affairs (15.4% versus 10.9%); illegitimate pregnancies (10.3 versus 8.2); and quarrels with spouse or parents-in-law (10.3% versus 8.2%). The common causes for suicide in India are disturbed interpersonal relationships followed by psychiatric disorders and physical illnesses. Spousal violence has been found to be specifically associated as an independent risk factor for attempted suicide in women.

## V. VIOLENCE AND ABUSE

According to an eye-opening United Nations report, around two-third of married women in India were victims of domestic violence and one incident of violence translated into women losing 7 working days in the country. Furthermore, as many as 70% of married women between the ages of 15 and 49 years are victims of beating, rape or coerced sex. The common forms of violence against Indian women include female feticide (selective abortion based on the fetus gender or sex selection of child), domestic violence, dowry death or harassment, mental and physical torture, sexual trafficking, and public humiliation. The reproductive roles of women, such as their expected role of bearing children,

the consequences of infertility, and the failure to produce a male child have been linked to wife-battering and female suicide. Sexual coercion is a serious and prevalent concern among female Indian psychiatric patients. Sexual coercion was reported by 30% of the 146 women in an Indian study. The most commonly reported experience was sexual intercourse involving threatened or actual physical force (reported by 14% of women), and the most commonly identified perpetrator was the woman's husband or intimate partner (15%), or a person in a position of authority in their community (10%). women are much more likely to require psychiatric treatment and are much more likely to attempt suicide than nonbattered women.[23] The cross-sectional data from a recent study, in India showed an association between violence and a range of self-reported gynecological complaints, low body mass index, depressive disorder, and attempted suicide. In summary, women are subjected to an alarming amount of violence in childhood and adulthood, and the effects of this violence are often profound and long-term.

### *Reproductive Health*

Mood and behavioral changes have been observed to be associated with menstrual cycle since ancient times. The symptoms such as irritability, restlessness, anxiety, tension, migraine, sleep disturbances, sadness, dysphoria, and the lack of concentration occur more frequently during the premenstrual and menstrual phase. A premenstrual dysphoric disorder consisting of extremely distressing emotional and behavioral symptoms is closely linked to the luteal phase of the menstrual cycle.Mental disturbances frequently occur during late pregnancy and in the

postpartum period. Postpartum blues is the most common and least severe postpartum illness affecting between 50% and 80% of new mothers, whereas postpartum depression constitutes a major depressive episode with an onset within 6 weeks postpartum in a majority of cases. In India. In a study in rural Tamil Nadu, the incidence of postpartum depression was 11%. Low income, birth of a daughter when a son was desired, relationship difficulties with mother-in-law and parents, adverse life events during pregnancy and lack of physical help are all risk factors for the onset of postpartum depression. The risk is highest among the most socially and economically disadvantaged women. The other important risk factors include gender-based factors such as the bias against female babies; role restrictions regarding housework and infant care; and excessive unpaid workloads; especially in multi-generational households in which a daughter-in-law has little autonomy, and gender-based violence.

Reproductive health factors, particularly gynecological complaints such as vaginal discharge and dyspareunia are independently associated with the risk for CMD. More importantly, gynecological symptoms may actually be somatic equivalents of CMD in women in Asian cultures.

### *Woman - A Life Cycle of Vulnerabilities*

As mentioned earlier, in many of the disorders, social factors and gender specific factors determine the prevalence and course in female sufferers. In fact, the numbers are meaningless without considering the sociocultural factors. Thus, depression, anxiety, somatic symptoms, and high rates of comorbidities are significantly related to interconnected and co-occurring risk factors such as gender based roles, stressors, and

The sociopolitical scene in South-East Asia including India in the mildest of terms is bleaker when compared to the Western world.[6,28] Wrath of dowry practices, a firm patriarchal family system with the woman having little say, lesser opportunities for education, and employment add to the plight of women. Women's mental health tends to suffer as they are faced with stressors and are ill-equipped to cope with the same.Furthermore, when a woman becomes mentally ill, services are sought infrequently and late. Rather she is blamed for the illness. Several studies show that there is greater distress in married women as compared to married men. The birth of a child, abortion or miscarriage, economic stresses, and major career changes are some of the stressful events in married life; many of these are gender specific.he responsibility of care for the mentally ill women is often left to her own family than to husband or his family.

### *Service Provision and Utilization*

Psychiatric epidemiological data cite a ratio of one woman for every three men attending public health psychiatric outpatients' clinics in urban India. Indian state officials view this as "under-utilization" by suffering women, attributing it to the greater stigma attached to women's mental illness that restricts help-seeking in public health facilities and/or to the lower importance accorded to women's health generally. Gender heightens the discrepancy between prevalence and utilization. This low attendance is partly explained by the lack of availability of resources for women in the hospital settings. The mental hospitals appear to cater primarily to men in distress, and there is sex-based discrimination in the availability of beds. The male:female ratio for the allotment of beds in government mental hospitals with only service was 73%:27% while those with service, research, and training was 66%:34%.

## VI. CONCLUSION

Analysis of mental health indices and data reveals that the patterns of psychiatric disorder and psychological distress among women are different from those seen among men. Symptoms of depression, anxiety, and unspecified psychological distress are 2–3 times more common among women than among men; whereas addictions, substance use disorders and psychopathic personality disorders are more common among men. The World Health Organization report lays out these facts effectively. It has further been suggested that observed gender differences in the prevalence rates originate from women and men's different average standings on latent internalizing and externalizing liability dimensions with women having a higher mean level of internalizing while men showing a higher mean level of externalizing.

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