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Psychopathology and Women In India

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INTRODUCTION

Right to health is one of the basic human rights. Women have been historically discriminated against, they are a group whose health concerns need to be prioritized, understood and researched.

Health is an important component of human development. With the rapid changes brought about through globalization and the resultant new economic order, there is an increase in the need for academic studies to be focused on the area of women's health.

There is a rising need to include gender dimensions in the health care policies and programes by the state, and to review the existing programs and policies as per the international standards. India is a State party to the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 of the ICESCR states, "The State parties to the present covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Reiterating the importance of the right to health, the Committee on Economic, Social and Cultural Rights, further emphasized the responsibilities of the State parties to protect the right of all groups and individuals to the enjoyment of the highest attainable standard of physical and mental health.

Ironically, in India despite the international commitment, women from the poorer classes and marginalized sections experience differential access to health care facilities. Women's health is one of the areas that deserve special concern .There is also a need to explore and understand the health concerns of women belonging to marginalized sections, since they are doubly vulnerable to discrimination .

It is estimated by the UN that in the developing world as a whole, one third of all pregnant women receive no health care during pregnancy. According to another UN estimate women account for 70% of the world's poor, and poverty, inequality and limited decision making power adversely impact women's health.

Working women have specific health concerns. With the rise in the number of working women in this age of globalization, new health problems are surfacing that the seminar proposes to deliberate upon. Health problems of working women have received inadequate attention. Stress of work coupled with domestic responsibilities, pregnancy related problems has taken a toll not only on women's physical health, but their mental health too, with large number of women being afflicted by common mental disorders including depression.

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PSYCHOPATHOLOGY AND WOMEN IN INDIA

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.

Psychopathology includes depression stress, anxiety and other mental disorders. Numerous factors affect the prevalence of mental health disorders among women in India, including older age, low educational attainment, fewer children in the home, lack of paid employment and excessive spousal alcohol use. There is also evidence to suggest that disadvantages associated with gender increase the risk for mental health disorders. Women who find it acceptable for men to use violence against female partners may view themselves as less valuable than men. In turn, this may lead women to seek out fewer avenues of healthcare inhibiting their ability to cope with various mental disorders, (Nayak and Patel,2010).

WOMEN'S MENTAL HEALTH: THE FACTS (WORLD HEALTH ORGANIZATION REPORT, 2001)

- 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.

One of the most common disorders that disproportionately affect women in low-income countries is depression. Indian women suffer from depression at higher rates than Indian men. Indian women who are faced with greater degrees of poverty and gender disadvantage show a higher rate of depression. The difficulties associated with interpersonal relationships—most often marital relationships—and economic disparities have been cited as the main social drivers of depression, (Pereira and Andrew, 2007).

It was found that Indian women typically describe the somatic symptoms rather than the emotional and psychological stressors that trigger the symptoms of depression. This often makes it difficult to accurately assess depression among women in India in light of no admonition of depression. Gender plays a major role in postnatal depression among Indian women. Mothers are often blamed for the birth of a female child. Furthermore, women who already have a female child often face additional pressures to have male children that add to their overall stress level,(Patel and Rodrigues,2002).

Women in India have a lower onset of schizophrenia than men. However, women and men differ in the associated stigmas they must face. While men tend to suffer from occupational functioning, while women suffer in their marital functioning. The time of onset also plays a role in the stigmatization of schizophrenia. Women tend to be diagnosed with schizophrenia later in

life, oftentimes following the birth of their children. The children are often removed from the care of the ill mother, which may cause further distress, (Loganathan and Murthy,2011).

There are no marked gender differences in the rates of severe mental disorders like schizophrenia and bipolar disorder that affect <2% of the population, (Piccinelli and Homen F Geneva, 1997). Gender differences have been reported, however, in the age of onset of symptoms, clinical features, frequency of psychotic symptoms, course of these disorders, social adjustment, and long-term outcome. The clinical features of bipolar disorder differ between men and women; women have more frequent episodes of depression, more commonly have "rapid cycling" and a seasonal pattern of mood disturbances,(Freeman MP and Arnold,2002). Large cross-cultural studies in schizophrenia have shown that "female gender" is associated with a better course and outcome of schizophrenia in the developing countries. Furthermore, females have a later age of onset of schizophrenia as compared to that in males.

Suicide

Indian women have higher rates of suicide than women in most developed countries. Women in India also have a higher rate of suicide compared to men. The most common reasons cited for women's suicide are directly related to depression, anxiety, gender disadvantage and anguish related to domestic violence, (Shahmanesh and Wayal, 2009).

Many of the high rates of suicide found across India and much of south Asia have been correlated with gender disadvantage. Gender disadvantage is often expressed through domestic violence towards women. The suicide rate is particularly high among female sex workers in India, who face numerous forms of discrimination for their gender and line of work.

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, (Rao V,2003). Biswas *et al(1997),* 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 sociocultural 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, (Maselko J and Patel, 2008). A large degree of attempts is as a response to failures in life, difficulties in interpersonal relationships, and dowry-related harassment, Biswas *et al(1997)*. 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,(Choudhary N and Patel V,2008).

Domestic violence

Domestic violence is a major problem in India. Domestic violence—acts of physical, psychological, and sexual violence against women—is found across the world and is currently viewed as a hidden epidemic by the World Health Organisation. The effects of domestic violence go beyond the victim; generational and economic effects influence entire societies. Economies of countries where domestic violence is prevalent tend to have lower female labour participation rate, in addition to higher medical expenses and higher rates of disability,(Kimuna and Yanvi,2012).

The prevalence of domestic violence in India is associated with the cultural norms of patriarchy, hierarchy, and multigenerational families. Patriarchal domination occurs when males use superior rights, privileges and power to create a social order that gives women and men differential gender roles. The resultant power structure leaves women as powerless targets of domestic violence. Men use domestic violence as a way of controlling behavior.

In a response to the 2005-2006 India National Family Health Survey III, 31 percent of all women reported having been the victims of physical violence in the 12 months preceding the survey. However, the actual number of victims may be much higher. Women who are victimized by domestic violence may underreport or fail to report instances. This may be due to a sense of shame or embarrassment stemming from cultural norms associated with women being subservient to their husbands. Furthermore, underreporting by women may occur in order to protect family honor.

A 2012 study conducted by Kimuna, using data from the 2005-2006 India National Family Health Survey III, found that domestic violence rates vary across numerous sociological, geographical and economic measures. The study found that the poorest women faired worst among middle and high-income women.[Researchers believe that the reason for higher rates of domestic violence come from greater familial pressures resulting from poverty. Additionally the study found that women who were part of the labour force faced greater domestic violence. According to the researchers, working women may be upsetting the patriarchal power system within Indian households.

Men may feel threatened by the earning potential and independence of women and react violently to shift the gender power structure back in their favour. One of the largest factors associated with domestic violence against women was the prevalence of alcohol use by men within the households. A 2005 study conducted by Pradeep Panda and Bina Agarwal found that the incidence of domestic violence against women dropped dramatically with women's ownership of immovable property, which includes land and housing,(Panda and Bina, 2005).

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, (Daver and Dennes Stein,1997).

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%),(Chandra and Carey,2003).

SUGGESTIONS

The more fundamental need is the woman/girl's education. Being educated provides awareness of rights and resources, the capability to fight exploitation and injustice. Education will also lead to better chances of economic independence, which is so crucial.

It is essential to develop and adopt strategies that will improve the social status of women, remove gender disparities, provide economic and political power, increase awareness of their rights, and so on. Although much depends upon the policy makers and planners, but women must also learn to speak for themselves. Women must act as social activists to fight against the social evils, which are responsible for their woes. Women's anti-alcohol movement in Andhra Pradesh where they destroyed the liquor shops to fight drunkenness of their husbands is a historical landmark. Similar movements to fight prostitution, sexual abuse, and domestic violence could be historical leading steps.

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.

Interventions at various levels aiming at both individual women and women as a large section of the society are essential. These should be implemented at primary care delivery as well on legal and judicial fronts. The primary care providers must be aware of the major mental health problems affecting women, routinely enquire about common mental health problems, provide the most appropriate intervention and support and provide education to the community on issues related to the mental health of women. Women are increasingly joining the workforce, and there is great potential to intervene at this level too.

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.

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