WOMEN AND MENTAL HEALTH: A Review

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Abstract:
This article reviews the importance of the mental health in Women population and how it is affected in them. Marked gender discrimination seen in the psychiatric illness and its acceptance in the society. The women are suffering from mental illness and the treatment is most of the time away from them, because of the stigma which the Indian society have. Women are discriminated from the society when the illness starts and keep them away from the treatment. This, along with family, social and work pressures, has a definite impact on women’s mental health.

Key words: Mental health, Women, Cultre, Psychiatric Disorders

INTRODUCTION
"Women have the right to the highest attainable standard of physical and mental health. The enjoyment of this right is vital to their life and well being…” (United Nations Beijing Platform for Action, 1995). Until recent years, the conception of women's mental health has been limited as have attempts to protect and promote it. When women's health issues have been addressed in under-served populations, activities have tended to focus on issues associated with reproduction - such as family planning and child-bearing - while women's mental health has been relatively neglected (WHO, 2000). Women with mental illnesses report more disability than women with other conditions and an earlier age of onset for disability. 45% of women with a mental disorder and activity limitation are between 18 and 44 years of age (Blehar, 2003). The burden of mental illness in women stems from general aspects of the epidemiology of some of the common mental disorders, viz, early onset—in adolescence or young adulthood, a recurrent or chronic course thereafter, although in later life there may be attenuation of symptom severity. For mothers with mental illnesses, there is added impact on child development and family functioning (Blehar, 2003).

WOMEN AND PSYCHIATRIC DISORDERS
Depression
Women are at greater risk for depression than are men, especially during the reproductive years (Epidemiologic Catchment Area Study; Regier et al.,1990) (National Comorbidity Survey; Kessler et al., 1993). For major depressive disorder (MDD), the National Comorbidity Survey (NCS) demonstrated a lifetime prevalence rate of 21.3% in women versus 12.7% in men—a female-to-male relative risk of 1.7. The lifetime prevalence rates of dysthymia showed a similar sex ratio, with rates of 8.0% in women and 4.8% in men (Kessler et al., 1994). Cross-national studies have also found rates of MDD to be higher in women; however, the sex ratio may vary among countries. There is conflicting evidence as to whether the gender difference in rates of depression disappears after midlife.

Some major theories proposed in an attempt to explain striking gender differences in prevalence rates of depression are as follows:
Artifact Theories- Some researches have questioned whether the sex differences in prevalence rates of depression are real or artifactual.
**Hormonal Factors**- The luteal phase of the menstrual cycle, which is a period of estrogen and progesterone withdrawal, is frequently associated with dysphoric mood changes as well as the onset or worsening of a major depressive episode (Endicott, 1993; Kornstein et al., 1996).

**Gender-Specific Socialization and Coping Styles**- Stereotypical gender socialization (girls being nurturing and concerned with evaluations of others, and boys' developing greater sense of mastery and independence in response to expectations of parents, teachers etc.) is hypothesized to lead to differences in self-concept and vulnerability to depression (Ruble et al., 1993).

**Stressful Life Events**- Studies have shown women to be more likely than men to experience the onset of depression following a stressful life event, particularly in response to stressors that involve children, housing, reproductive problems (Kendler et al., 2005), and depression is common in women with a history of sexual abuse (Weiss et al., 1999).

**Social Status and Roles** - Some of the common risk factors of depression in women are poverty, single motherhood (Brown & Moran, 1997), lower educational attainment, fewer opportunities and salary inequities in the workplace, unhappy marriages (Wu & DeMaris, 1996) and divorce (Horwitz et al., 1996).

**Bipolar Disorder**

The presentation of bipolar disorder in women differs from that in men in clinically significant ways. Bipolar I disorder occurs equally in both sexes, while Bipolar II disorder occurs more frequently in women than in men (Dunner, 1998). The course of bipolar disorder in women differs from that in men in several ways. First, women generally have a later age of onset, with onset during the fifth decade of life being more common (Leibenluft, 1996). Second, "rapid cycling" is about three times more common in women than men. In studies of rapid cycling, the percentage of female patients has ranged from 58% to 92%, with a mean of approximately 71% (Leibenluft, 1997). Finally, in women, depressive episodes occur more commonly in the fall and winter than in the spring and summer (Faedda et al., 1993).

**Schizophrenia**

Women consistently demonstrate a later age of illness onset than men do (Blehar, 2003). Whereas, the peak age of onset for women is between 25 and 35, the illness typically strikes men between the ages of 18 and 25 (Angermeyer & Kuhn, 1988; Goldstein et al., 1990). In a follow-up study of chronic inpatients women consistently ranked higher in premorbid sexual and social functioning than men (McGlashan & Bardenstein, 1990). In a study of people with schizophrenia living in a community setting, Test et al (1990) found that women were more often parenting children, living with a partner, and heterosexually active, indicating higher social functioning (Blehar, 2003). Research from a large patient sample showed fewer hospitalization days annually and a lower risk for rehospitalization for women with schizophrenia than men (Angermeyer et al., 1990).

**Anxiety Disorders**

Estimates based on data from the Epidemiologic Catchment Area (ECA) study and the NCS suggest that lifetime prevalence rates in females, for panic disorder (3.4% vs. 0.9%), agoraphobia (9.0% vs. 3.0%), specific phobia (13.9% vs. 7.2%), generalized anxiety disorder (GAD) (7.7% vs. 2.9%), and posttraumatic stress disorder (11.3% vs. 6.0%), are two to three times greater than those demonstrated in males (Kessler et al., 1994; Regier et al., 1988; Robins et al., 1984; Boyd et al., 1990; Joyce et al., 1989). Females are more frequently afflicted with anxiety disorders at every age, although the overall incidence decreases with advancing age. There is a narrowing in the gender difference for anxiety disorder prevalence rates after the age of 65 years (Krasucki et al., 1998). Increased anxiety sensitivity has been reported to occur in the
luteal, in comparison to the follicular, phase of the menstrual cycle (Fishman et al., 1994). Elevated rates of anxiety symptoms are also reported during perimenopause; the presence of very high levels of follicle-stimulating hormone during this period may be helpful in distinguishing women who have depression or anxiety disorders from those who are merely perimenopausal (Huerta et al., 1995).

**Generalized anxiety disorder (GAD)**

Most studies report a two- to threefold greater lifetime risk for GAD in females than in males. The onset of GAD is typically during late adolescence or early adulthood, and most studies suggest that a chronic, persistent course is most common (Kessler et al., 1994; Woodman et al., 1999). Prevalence of GAD remain constant throughout life (Krasucki et al., 1998). Complicated GAD (GAD with a coexisting psychiatric disorder) is much more likely to occur in females than in males. Moreover, depressive disorders such as dysthymia coexist more frequently in females with GAD (Wittchen et al., 1994; Yonkers & Ellison, 1996). Greater symptom severity and a more chronic course are reported for GAD in female than in males (Yonkers & Ellison, 1996). Kendler and colleagues (Kendler et al., 1992, 1995; Kendler, 1996) suggest that a shared genetic basis (genotype) may determine the risk for subsequent development of GAD and depression. That is, GAD and depression may represent separate expressions (phenotypes) of the same underlying genotype in females. Kendler (1996) hypothesized that a confluence of environmental and biological factors may ultimately determine whether GAD or depression is expressed when the genotype is present within an individual. Little is known about the impact of the female reproductive cycle on the development or course of GAD.

**Panic disorder**

Data from epidemiological surveys indicate that females are two to three times more likely than males to develop panic disorder (Kessler et al., 1994; Weissman et al., 1997). Most reports suggest that panic disorder typically emerges in the mid-twenties (Eaton et al., 1991; Kessler et al., 1994), although some reports have suggested additional peaks of onset during adolescence (Weissman et al., 1997; Reed & Wittchen, 1998) and between 30 and 40 years of age (Dick et al., 1994a). Females with panic disorder report more individual panic-related symptoms and a greater level of phobic avoidance than males (Dick et al., 1994a). Females with panic disorder are also more likely to report situations such as leaving home or using public transportation as precipitants for panic attacks (Starcevic et al., 1998), indicating greater levels of dependence and functional impairment in comparison to males.

**Specific phobia**

Specific phobia occurs twice as often in females as in males. Population surveys indicate that females are two to three times more likely than males to have the situational type of specific phobia (Dick et al., 1994b). Similarily, lifetime prevalence estimates suggest that animal phobias are two to three times more common in females. In contrast, no gender difference occurs in prevalence rate for the health-related type of specific phobia (Fredrikson et al., 1996). Some reports have suggested that females may have a significantly earlier age of onset for specific phobia (Dick et al., 1994b).

**Social anxiety disorder**

Lifetime prevalence estimates suggest that females have a slightly higher lifetime prevalence risk for social anxiety (1.5 times; 15.5% vs 11.15%) than males (Kessler et al., 1994; Dick et al., 1994b). However, men may seek treatment significantly more often than women when social anxiety disorder is present (Weinstock, 1999). However, women reported
significantly greater fear in association with a wide range of activities, including talking to authority figures, acting/performing/speaking/working in front of others or while being observed, expressing disagreement or disapproval to people they did not know very well, or giving a party. Other reports have suggested that agoraphobia may co-occur at a greater rate in females than in males with social anxiety disorder (Lecrubier & Weiller, 1997).

**Obsessive Compulsive Disorder (OCD)**

Males typically have an earlier onset of OCD than females. Dopamine dysregulation may be more prominent in males with OCD, whereas gonadal steroid hormones and their complex interactions with serotonin may be more critical to the development of OCD in females. The dramatic shift that occurs in gender prevalence rates for OCD after the onset of puberty provides support for the importance of female reproductive hormones. Females begin to develop OCD at a much greater rate than males after menarche; the increase is so robust that the overall prevalence rate in OCD is greater for females (1:5:1) than males (Weissman et al., 1994). Gender differences have also been identified in the phenomenology and clinical course of OCD. Aggressive obsessions and cleaning compulsions may occur more frequently in females with OCD (Castle et al., 1995). Adolescent females endorsed a greater amount of compulsive rituals, whereas obsessions were more common in adolescent males with OCD. Women with OCD may also have a more episodic clinical course and less severe symptoms.

**Post Traumatic Stress Disorder (PTSD)**

PTSD is reported to be twice as common in females (10.4%) as in males (5%). The most common causes of trauma leading to PTSD in men are combat exposure or witnessing someone being injured or killed. In contrast, women are most likely to develop PTSD as a consequence of sexual assault, sexual molestation, or childhood physical abuse (Brunello et al., 2001). Breslau et al., (1997a) found that following similar rates of exposure to traumatic events, substantially more females than males met criteria for PTSD. Females appeared to have a markedly increased susceptibility for PTSD development, especially if the trauma occurred prior to age 15 (Breslau et al., 1997a; Kessler et al., 1994a). Preexisting depression appears to convey an increased risk for subsequent exposure to traumatic events, as well as for the development of PTSD once trauma occurs (Breslau et al., 1997b).

**Alcohol and Other Substance Abuse**

A number of social factors differentiating women from men with regard to substance use have been identified (Brady & Randall, 1999). Women experience more social disapproval of substance use, and substance use is more stigmatized in women than in men (Blume, 1986). Women with alcoholism are more likely than men to have alcoholic role models in their nuclear families and to have spouses who are also alcoholic (Lex, 1991). Substance use for men is more likely to affect jobs or career, whereas disruptions for women are more likely to occur in family life. More women with substance use problems are separated or divorced compared with men (Lex, 1991). Women are more likely to attribute their drinking to a traumatic event or a stressor (Lex, 1991), and women who abuse alcohol and drugs are more likely to have been sexually or physically abused than other women (Gearon et al., 2003). In addition, women with alcoholism are more likely than men to have another mental disorder, most often depression (Stein & Cyr, 1997). For some women employment may actually be a protective factor, whereas for others it may be a facilitative factor (Ames & Rebhun, 1996). The relationship between alcoholism and anxiety in women has been documented repeatedly, but it remains unclear whether the anxiety conditions are a lifelong disorder or temporary conditions related to intoxication and withdrawal. Women with alcoholism under age 40 are five times more likely to attempt suicide than
nonalcoholic women (Centers for Disease Control and Prevention, 1995). The suicide rate for women equals that for men among adults with alcoholism. Stein and Cyr (1997) reported that the following factors are associated with increased risk of alcohol problems in women: 1) drinking to improve psychological function (e.g., shyness, anxiety) in young adulthood 2) low self-esteem in adolescence 3) poor coping skills in adolescence 4) family history of alcoholism (particularly in father) 5) severe premenstrual syndrome 6) concomitant psychiatric diagnosis (depression, anxiety) 7) lifetime use of drugs other than alcohol 8) history of rape or incest 9) fertility problems 10) heavy-drinking partner 11) sexual dysfunction 12) eating disorders 13) low utilization of prenatal care 14) domestic violence 15) suicidality

**Eating Disorders (ED)**

Eating disorders are more common in women that in men (Andersen & Holman, 1997). About 95-97% of patients with Anorexia Nervosa (AN) and about 80% patients with Bulimia Nervosa (BN) are female. The three most important physiological complications among female patients with AN are osteoporosis, cardiac complications, and renal abnormalities (Gucciardi et al., 2004).

Included in the ED NOS category, "binge-eating disorder" (BED), characterized by episodes of binge eating not followed by compensatory behavior to prevent weight gain and resulting in overweight or obesity is similar to BN in that it is more common in females (60-70%) and often associated with depression (Robertson & Palmer, 1997). It involves body image disturbances and cognitive distortions (e.g., dichotomous, all or-none thinking). Another condition, "night-eating syndrome" (NES) occurs in a subgroup of female patients with difficult-to-treat obesity (Rand et al., 1997), and it is characterized by morning anorexia, consumption of 25% or more of the daily calories after the evening meal, initial insomnia (inability to fall asleep), and evening tension. The "Female athlete triad" refers to disordered eating, amenorrhea, and osteoporosis that frequently occur in elite female athletes (Nattiv et al., 1994). Although this term does not appear in the formal nomenclature, it is being increasingly used by athletic personnel and conceptually belongs in the ED NOS category of DSM-IV.

**Menstrual irregularities**- Amenorrhea is a key symptom in females with AN, and is associated with the development of osteoporosis (Powers, 1999). Many patients with BN also have irregular menses.

**Infertility**- Bulik et al. (1999) found that 17% of women aged 21-39 who presented to an infertility clinic had eating disorders. Bates et al. (1982) found that among underweight women with eating disorders who presented to an infertility clinic willing to gain weight, 73% were able to conceive.

**Pregnancy**- Bulik et al. (1999) found that compared to controls, women with a history of AN had more miscarriages and cesarean deliveries, and babies of women with AN were more likely to be born prematurely and were of lower birth weight than infants of control women. Most patients with BN are able to conceive. Some patients with BN are able to suspend binge eating and purging during pregnancy, but the symptoms often recur following delivery. There is also a high rate of maternal and/or fetal complications among patients with BN (Blais et al., 2000; Morgan et al., 1999).

**Somatoform Disorder**

The ECA study found an lifetime prevalence of somatisation disorder in men of 0.02% compared to 0.23% in women (Swartz et al., 1991). According to Wool and Barsky (1994) women have higher rates of somatisation as somatic symptoms are more culturally approved in women than men, associated psychiatric disorders (mood and anxiety disorders) are more
common in women, women have higher rates of childhood physical and sexual trauma and innate sensitivity to bodily sensations. There is no marked difference in clinical presentation between men and women, except for dizziness being more common in women (Golding et al., 1991). The rate estimates for hypochondriasis are variable. Like somatisation disorder conversion disorder is more common in females than men (Boffeli & Guze, 1992).

**Body dysmorphic Disorder (BDD)**

BDD appears to be relatively common but undiagnosed in women. The reported sex ratio of BDD has varied in different studies. While age of onset for BDD appears to be similar for males and females (Albertini & Phillips, 1999); women with BDD are most preoccupied with their skin, hair, nose, hips, weight (Phillips & Diaz, 1997), and also face, breasts and legs (Perugi et al., 1997). They are more likely than men to check mirrors and use camouflaging behaviours (Perugi et al., 1997). A low percentage of BDD women are married and few have children. They are too self conscious and ashamed of their appearance to be in a relationship, avoids sexual relationship and do not want children for worry that they would have similar deficits (Laugharne et al., 1997). Women with BDD are more likely to have comorbid bulimia nervosa (Phillips & Diaz, 1997), panic disorder, GAD (Perugi et al., 1997).

**Alzheimer’s Disease**

Women are disproportionately prone to Alzheimer’s disease, even after adjustment for their longer survival. As many as 30%–50% of women older than 85 years suffer from dementing process (Bachman et al., 1992). Women’s cognitive impairments may also be more severe than men’s (Henderson & Buckwalter, 1994). Part of the increased understanding of the puzzle of Alzheimer’s disease lies in the clarification of the effect of estrogens on neurotrophins, proteins that play both individual and combined roles in the sustenance of neuralaxons and dendrites and also in the growth of new nerve cells. This hormonal modulation of neurotrophins increases the connections among neuronal branches and maintains a complex system of communication in the brain (McEwen, 1991). When estrogen levels drop at menopause, brain cells of women begin to degenerate at a faster pace than those of men. Men are relatively spared because their continuing testosterone secretion is converted, to some extent, to estradiol in the brain. This hypothesis has been supported by studies which show that estrogen replacement therapy prevents, or at least delays, the onset of Alzheimer’s disease (Paganini-Hill & Henderson, 1996) and may even improve memory in Alzheimer’s patients (Henderson et al., 1994). The neurotrophin route is only one of the ways in which estrogens may act to protect against Alzheimer’s disease. Estrogens are also antioxidants, protecting neurons against β-amyloid, one of the proteins that accumulates in patients with Alzheimer’s disease to produce neuronal degeneration (Goodman et al., 1996). Estrogens also modulate the secretion of acetylcholine in the hippocampus by their effect on choline acetyltransferase, an enzyme critical to the maintenance of memory functions (Wickelgren, 1997).

**Sexual Dysfunction**

Pregnancy influences sexuality, primarily related to the presence of dyspareunia and diminished orgasmic capacity (Oruc et al., 1999). Menopause, with its decline in estrogen and testosterone, may lead to decreased libido (Chiechi et al., 1997), dyspareunia associated with vaginal dryness, and other sexual dysfunction. Body image, general health status, psychological issues, relationship status, and beliefs about sexuality, may also influence sexual functioning in the climacteric (Kingsberg, 1998). Sexual functioning in older, postmenopausal women may be influenced by psychological issues of aging, medication, and illness-related factors (Meston, 1997).
Primary sexual dysfunction- In women, sexual dysfunctions include hypoactive sexual desire disorder, sexual aversion disorder, female sexual arousal disorder, and female orgasmic disorder. They also include two sexual pain disorders, dyspareunia and vaginismus. Epidemiological data from the 1992 National Health and Social Life Survey (NHSLS) in U.S. adults (1,749 women and 1,410 men) indicated that sexual dysfunction was more prevalent in women (43%) than in men (31%), with different patterns of sexual dysfunction between genders. Younger women reported more problems with sexual desire and difficulty achieving orgasm than did older women. Nonmarried women reported orgasm problems at 1.5 times the prevalence rates in married women. Women with lower educational attainment described less pleasurable sexual experiences and higher levels of sexual anxiety than did women with higher educational attainment. Poor physical health was correlated with sexual pain in women in the NHSLS. In the Dunn et al. (1998) report, dyspareunia was found to decrease with age.

Secondary sexual dysfunction- Psychiatric conditions may affect sexual functioning in all phases of the sexual response cycle. Apt and Hurlbert (1994) reported lower sexual desire and greater orgasmic dysfunction in women with histrionic personality disorder, and 60% of women with schizophrenia versus 13% of normal volunteers reported having never experienced an orgasm (Friedman & Harrison, 1984). Psychotropic medications are much more likely to produce untoward effects on sexual functioning than positive effects. Thoridazine (Kotin et al., 1976), trifluoperazine (Degen, 1982), and fluphenazine (Ghadirian et al., 1982) have been reported to induce anorgasmia in females. Sangal (1985) reported inhibited female orgasm as a side effect of alprazolam. Clayton et al. (1999) reported that 52.5% of women treated with selective serotonin reuptake inhibitors (SSRIs) experienced sexual dysfunction.

Personality Disorder (PD)

Nurnberg et al (1999) found that females are predominantly sociable, need relationships, undervalue themselves, sensitive to criticism, self-sacrificing, and emotionally expressive with a more adaptive and autoplasic mode of functioning. There may be underreporting of rates of female juvenile delinquency and biases exist in beliefs about how an adolescent girl demonstrates antisocial behavior (thought to be manifesting itself as precocious sexual activity) and that women are less violent (Pajer, 1998). Although the most common pathological outcome for boys with antisocial behavior has been shown to be adult criminality, the adult course for girls has been assumed to be more benign. Rutherford et al. (1999) found a weak relationship between the childhood and adult antisocial behaviors seen in women. Work by Caspi et al. (1993) indicates that precursors of antisocial behavior in women may be more closely related to the early taking on of adult roles and norm-breaking behaviors as a way of obtaining adult possessions (e.g., money, clothes, drugs). Pajer (1998) found that childhood maltreatment is a risk factor for adult Antisocial PD (ASPD) in males but not in females. Borderline PD (BPD) is commonly assumed to be more prevalent in women. Paris (1997) has reviewed the phenomenology, behavioral symptoms, epidemiological studies, risk factors, outcome, and treatment of BPD and ASPD and concluded that "similar traits in men and women can have different behavioral expression...... Impulsivity in men is more likely to be expressed through exploitation of others, whereas impulsivity in women is more likely to be expressed in self-destructive behaviour".

WOMEN AND THESOCIOCULTURAL SCENARIO

Gender is a critical determinant of mental health and mental illness. Gender determines the differential power and control men and women have over the socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their...
susceptibility and exposure to specific mental health risks. Gender specific risk factors for common mental disorders that disproportionately affect women include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others (WHO, 2007).

**Women’s mental health: Some Bare Facts** (WHO, 2007)

- 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.

**Basic issues**

Many of the issues that damage the physical health of women, such as poverty, inadequate nutrition and unsafe water, also contribute to poor mental health (Stewart et al., 2001). Approximately 70% of the 1.2 billion persons who live in poverty are women who live with dependent children or alone. In many countries, women are paid 30% to 50% less than men for the same work. Women are also more likely than men to do informal, low-status, sometimes dangerous work, often without even minimal pay (Stewart et al., 2006). Chronic poverty, sexual discrimination, no access to healthcare or education for herself and her children, exclusion from community participation, unfair labor practices and overwork all may contribute to poor mental health. Many women work a "double day" maintaining households, raising children, carrying out economically productive activities in marketing and agriculture and in household-based industries. Numerous studies document that women "work" more hours than do their husbands given their widely diverse economic and household responsibilities (Norma et al., 1997). Increasingly, women are becoming an essential part of the labour force and in one-quarter to one-third of households they are the prime source of income (WHO, 2005). The multiple roles that they fulfill in society render them at greater risk of experiencing mental problems than others in the community.

A lack of proper nutrition puts girls and women at greater risk for physical and mental illness. In all regions of the world, fertility rates are declining but maternal mortality is still the leading cause of death for women of reproductive age in developing countries. In addition, infant mortality rates are highest in high-fertility regions, and they remain a source of great psychological stress for women. It is very difficult for girls and women to develop self-esteem and good mental health when their lives are considered less valuable than the lives of males (Stewart et al., 2006).

**Violence**

Violence against women, a human rights abuse and a violation of security, dignity and fundamental freedom, impairs women's physical and mental health throughout the world (Stewart et al., 2001) Violence may occur during acts of war or civil unrest, when sexual assault and rape are distressingly common. At other times, the greatest risk of violence for women comes from their male partners. **Domestic violence** is experienced by 10% to 50% of women throughout the world, but it is often underreported to save family reputation, or disregarded or condoned by state, religious and law enforcement officials (Stewart et al., 2001). The various kinds of violence perpetrated on women include forced abortion of female fetuses, forcible
genital mutilation, forced marriage, incest, prostitution, pornography, dating and courtship violence, economically coerced sex, sexual abuse in the workplace, rape, sexual harassment, dowry abuse and murder. With the globalization of demand and resources, the trafficking of women who have been forced into prostitution has spilled into the developed world (Stewart & Gajic-Veljanoski, 2005). The victims are usually young women from poor families of poor countries. Besides other problems, prostitution places women at high risk for HIV/AIDS and other sexually transmitted diseases, gynecologic problems, headaches, traumatic injury and chronic pain (Stewart et al., 2006).

The mental health consequences of all types of violence against women are enormous, and may result in post-traumatic stress disorder, depression, anxiety, low self-esteem, sexual dysfunction, self-inflicted harm and suicide (Stewart et al., 2006).

Education

Education is the key to power, physical and mental health, proper nutrition, economic wellbeing, fertility control, social status and participation in social development (UNICEF, 2004). Education of women also leads to assertiveness, empowerment and better mental health. The schooling of girls leads to an increase in child survival, a decrease in fertility and positive impacts on agricultural production and economic growth (Stewart et al., 2001). Social risk factors for depression, such as domestic violence, may also be reduced through girls' education (Stewart et al., 2001). Twice as many women as men are among the world's 900 million illiterates. Major problems continue to exist in many African and Asian countries, where the proportion of boys attending school greatly exceeds that of girls (Stewart et al., 2006).

Indian Scenario

Edwina et al (2005) studied 102 women of Tamil ethnicity to assess the psychological symptoms with possible common mental disorders in a primary care setting through self report questionnaires. It was found that nearly three fifths scored above the cut off point. Age, physical illness and chronic pain were found to be important factors in the genesis of depression in particular.

Promotion of Mental Health in Women

In September 2005, the World Psychiatric Association and its 142 national psychiatric associations enthusiastically endorsed the International Consensus Statement on Women's Mental Health developed by the International Association of Women's Mental Health (Stewart, 2006).

Recommendations

1. Support psychological health promotion programs that include equal access to basic human rights, education and employment, the elimination of violence and discrimination and the reduction of poverty.
2. Support women's marital, sexual and reproductive choices and ensure access to safe motherhood.
3. Support public education and awareness campaigns that increase recognition and reduce the stigma of mental illness in girls and women.
4. Support safe, respectful, appropriate, gender-sensitive comprehensive mental health and physical health services for girls and women.
5. Support timely access to adequately skilled mental health professionals.
6. Support the provision of accurate information and respect choices in treatment decision making by girls and women whenever possible.
7. Support increased attention to research on girls' and women's mental health including those factors that enhance or inhibit the development of resiliency.

8. Support the provision of core training and education about gender issues for health, and mental health, professionals.

9. Support gender equality in practice and promotion within mental health services and organizations.

**Recommendations for Specific Initiatives in Mental Health Services and Training**

1. Upgrade the amount and quality of mental health services through training for workers at all levels, from medical students to graduate physicians, from nurses to community health workers.

2. Promote efforts to improve state gender policies, toward interdicting violence against women, and toward empowering women economically, and to make women central in policy planning and implementation of mental health services. Research should evaluate the mental health consequences of these programs for women, for children, and for men.

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

4. Direct efforts specific to primary prevention of mental disorders, and behavioral, psychosocial and neurological disorders.

**CONCLUSION**

The mental health of women must be considered in the context of women’s lives and can be understood only if their biological, social, cultural, economic and personal context is considered. Overall, women and men do not differ in the lifetime likelihood of meeting criteria for a mental disorder but they differ markedly in the prevalence and clinical course of many classes of disorders. Prevalence of depression, GAD, panic disorder, OCD, PTSD, eating disorder and somatisation disorder are significantly greater in women. These gender disparities are thought from a constellation of biological and experiential differences between the sexes. Genetic, hormonal, neurodevelopmental, and neurophysiological sex differences as well as physiological differences in stress reactivity and experiences of stress have been linked to gender disparities. Females also have unique hormonal transitions and predictable developmental roles, which require special consideration. Early and appropriate pharmaceutical intervention along with a gender-based, social model of health to investigate critical determinants of women’s mental health must be resorted to, with the overall objective of contributing to effective prevention and promotion of women’s mental health.
REFERENCES


