Absence of Women's Needs in the National Mental Health Programme of India

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Abstract

The National Mental Health Programme came in 1982. The issue of mental health was highlighted in India with the beginning of this program which later on helped in bringing out mental health Act 1987. Globalization has changed the lives of everyone in some or the other way. In this technologically advanced social scenario, the situations and circumstances of women have not only improved but also have become susceptible to all sorts of violence. This has made a growing need to look at the mental health needs for women at the psychiatric as well as psychosocial level. The National Mental health Act tried to address the mental health needs of everyone. However, research in the area of women's mental health had revealed that women's biological as well as psychosocial situations are far different than men and hence her mental health needs shall be addressed in different manner with special reference to the continuous role addition on women without any substitution. The present paper attempts to look at the absence of women needs in the NMHP. On the basis of the researches done in the areas of pattern and prevalence, socio-demographic variables and access to mental health services by women, the paper tries to emphasize that there is a need to address the mental health needs of women at the level of policy making. The interventions for addressing women's needs are also suggested.

Keywords: National mental health programme, psychiatric, psychosocial, interventions

Background

Mental health describes a level of psychological well being, or an absence of a mental disorder.

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The World Health Organisation defines mental health as *"a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".* In 1975, on the recommendation of WHO the government of India felt the necessity of evolving a plan of action aimed at the mental health component of the National Health Programme. In august 1982, the highest policy making body in the field of health in the country, the Central Council of Health and Family Welfare (CCHFW) adopted and recommended for implementation of NMHP. With the efforts of NIMHANS, Bengaluru (Murthy et.al, 1978; Wig et.al 1981, Chandrashekhar et.al 1981, Kapur et.al 1982, Issac et.al 1982) and PGIMER, Chandigarh, the National Mental health Program (NMHP) was formulated in India (Srinivas Murthy R.2000). It was a nation level initiative for mental healthcare based on the community psychiatric approach. It was realised that mental health must form an integral part of the total health programme and as such should be included in all national policies and programes in the field of health, education and social welfare.

Since that time, the Act has been questioned and mental health bill has been drafted number of times in order to modify and meet the shortcomings of NMHP. The highlights of the Annual report on Health of the ministry of Health and Family welfare, released in September, 2010, relating to mental health are: "to increase the availability of trained personnel required for mental health care, 7 regional institutes have been funded against the 11 that were to be set up during the Eleventh Five year plan for the production of clinical psychologists, psychiatrists, psychiatric nursing and psychiatric social workers. Further, support has been provided to 9 institutes for 19 PG (postgraduate) programmes during the year 2010 for man power development (Annual Report, 2010). There is a history of struggle for mental health services in India since its independence when by the efforts of Dr. Vidya Sagar of Amritsar (1973) who innovated that there should be an active role of families in the treatment of mentally ill patients in the hospitals. During the last 3 decades, there have been a large number of other community initiatives to address a wide variety of mental health needs of the community through programmes on suicide prevention, care of the elderly, substance abuse and disaster mental health care, and by setting up of day care centres, half way homes, long stay homes and rehabilitation centres. However, still the mental health is an unmet need in India.

The objectives of the NMHP were: (1) to ensure the availability and accessibility of minimum mental healthcare for all, particularly to the most vulnerable and underprivileged sections of the population, in the foreseeable future; (2) to encourage the application of mental health knowledge in general healthcare and in social development; and (3) to promote community participation in the development of mental health services and to stimulate efforts towards self-help in the community.

The approaches advocated by the NMHP were; diffusion of mental health skills to the periphery of the health service system; appropriate appointment of tasks in mental healthcare; and integration of basic mental healthcare into general health services and linkage to community development and mental healthcare. The service component included 3 sub-programmes-treatment, rehabilitation and prevention.

During the period from 1982 to 2013, a lot of modifications and improvement took place in the NMHP. The most important step was the initiation of district mental health program (DMHP). This was initially started in 4 states, then to 25 districts in 20 states and over 125 districts by 2010 (Isaac et.al 1986, Kumar A, 2005). In the tenth and eleventh five year plan, lot of initiatives were taken to improve the infrastructure, faculty and services of various medical and research bodies. The ICMR, New Delhi, gave a big push to mental health research in the 1980's. This research has not only brought to light the importance of understanding mental disorders such as schizophrenia in the cultural context, but has also shown the feasibility of developing models involving schools, primary healthcare and general practitioners, as well as working with families. This new knowledge has continuously supported the development of mental health programs.

Challenges before NMHP

National Mental Health Programme has been questioned by researchers. There is a substantial contribution by Bhargavi Davar, (2001) in several ways. Firstly she offered a systematic critique and was the first gender-sensitive critique in our country of studies on prevalence of mental health that have either back seated or drawn erroneous inferences regarding mental health of women. Second, it makes a forceful critique of the present mental health policies such as the National Mental Health Programme (NMHP, introduced in 1982) that are not adequate to deal with women's mental health.

Third, it proposes an alternative conceptualisation of women's mental health needs on a feminist and phenomenological basis, balancing between the viewpoint that emphasizes mental illness as a social construct and the phenomenological perspective that accords relevance of the experiential reality of subjective experiences of stress.

Davar (1995) draws attention to the paucity of even basic information in our country on gender differences in the pattern and prevalence of mental disorders and in access to health care services and on the specific vulnerabilities of women in various ages, occupational and socio-economic groups. Epidemiological studies of mental health, conducted since the 1960s do not provide a coherent picture of mental disorders among women but make questionable assumptions and methodologically dubious inferences on the state of mental health of women. For instance, Davar points out that these studies record a greater representation of male patients in hospital statistics. Based on this data, it is erroneously concluded that men suffer more mental illness due to the greater stressful burden associated with the male role in Indian society.

Davar argues that such conclusions are wrongfully drawn as they overlook the higher prevalence of mental disorders in women reported from community surveys and the world-wide trend, the existing gender bias in access to health care services, and the emerging women's movement literature on how women's position in society and their work and roles might contribute to poor health outcomes. Drawing from the same data generated by epidemiological investigations, Davar constructs a profile of women's mental disorders. While no gender differences were seen in severe mental disorders that have a biological basis, women were found to be at least twice as frequently ill as men in the case of common mental disorders whose aetiology is linked to psychosocial causes. Thus disorders such as unipolar depression, anxiety and somatization disorders that disproportionately affect women are seen to be linked to psycho social causes such as their position in society and the work they do rather than to biological/organic factors. The fact that women suffer more from common mental disorders underscores the necessity of adopting an approach different from that of the NMHP to women's mental health concerns.

The NMHP was and remains basically a psychiatric preserve and is characterized by an illness-driven approach to mental health. Because of its exclusive reliance on the bio medical approach, the NMHP prioritises severe mental disorders such as psychoses, epilepsy and mental retardation, for intervention and therapies such as electrotherapy and chemotherapy that are more suited for such disorders and that are the dominant modes of treatment in most psychiatric institutions. Such a prioritisation is especially problematic for women as the disorders and treatment needs of women are markedly at variance from those espoused by mental health policies of the state. The bio-medical approach underlying the mental health programme is thus not oriented to women's mental health needs, as it is to deal with severe disorders and not to disorders that have more of a psychosocial causation, as in the case of women.

Clinicians therefore need to discriminate between what Davar (1999) calls an 'illness language' from a 'distress language' which is more appropriate for women. Whether women's needs should be treated differently or whether there should be an identical treatment with men in view of formal equality has been a vexed issue. Davar argues that women's mental health should be addressed within the context of both gender equality and sexual difference. This will make (or ought to make) clinicians treat certain issues as non-negotiable such as those related to violence, discrimination and abuse and at the same time will allow them to view women's special needs related to reproduction and sexuality with particular care.

Davar's work is particularly significant because it establishes a dialogue between feminism and the mental health sciences, between activists and practitioners, bridging the gap between feminist advocacy and the seemingly 'value-neutral' clinical practice Vindhya, U. (2007).

Need for a gender sensitive Approach

The globalized world has increased the opportunities and areas where women can express their talents, abilities and cultivate them in most effective ways. Impact of globalization is widespread and it has affected the lives of everyone in a very systematic way. Globalization refers to the expansion of global linkages, the organization of social life on a global scale and the growth of a global consciousness, the consolidation of the world society had taken place.

There is integration of markets, nation states, and technologies to a degree never witnessed before in a way that is enabling individuals, corporations and nation-states to reach around the world farther, faster, deeper and cheaper than ever before. Globalization has affected the lives of Indian women both in a positive and in a negative manner. On one hand, there are broader communication lines and brought more companies as well as different worldwide organizations into India. This led to more and more employment opportunities for women, who became larger part of the workforce. With new jobs for women, there are opportunities for higher pay, which raises self confidence and brings about self confidence and brings about independence, the two necessary conditions to make women empowered. This in turn helped in reducing some gender gap. Globalization has power to uproot the traditional views towards women so that they can have equal status in the society. However, this increased the role conflict in women even in a more pronounced way. Families became nuclear, small and are not acting as a buffer system at the time of stress.

The impact of globalization has some negative effects also. Globalization has made many international corporate richer by billions. However, most people are not aware of the fact that women in these developing countries are suffering enormously due to this expansion of corporate empires. According to World Development indicators, "women work two-thirds of the world's working hours, produce half of the world's food, but earn only ten percent of the world's income, and own less than one percent of the world's property". Women are suffering twofold. As women moved into work force, their domestic responsibilities are not alleviated. Women work two full time jobs. The mixture of corporate capitalism and Western culture models is dissolving family models and community social controls as witnessed by higher rates of family violence, rape, divorce, and family breakdown. Fast pace development in technology and acceptance of these developments in every domain of life which has made life comfortable, easy and restless. These advancements has made people not only alert and attentive but also increased their levels of anxieties. This situation is even more complex for woman because she is not only susceptible to these changes but also taking the extra psychological burden of role conflicts. The picture is variegated in different classes, castes, and religious communities. Indian women in the slums has been socialized in a way that she is not able to exercise control, autonomy and choice on her major domains of life even in the case of their reproductive health as their relational selves dominate over their independent selves (Varma & Sahai, 2013).

However, the educated Indian women exercise control, autonomy and choice on major domains of their lives and this gives them a sense of subjective well being as socialization factors were considered as important determinants. (Varma & Dhawan, 2006).

The present paper is an attempt to understand the mental health issues of women as reported in psychological research, specifically in terms of prevalence, socio demographic relationships, with reference to role conflicts and access to mental health services. The paper also aims to bring into prominence the relative absence of women in mental health programme of India. Finally, author tries to delineate some suggestive interventions to improve women's mental health.

Mental Health Issues of Indian Women

It is hard to believe that whenever women's health needs are addressed, it is confined to physical and at the most reproductive. Women's health is conceived more as *functional* rather than *physiological*. Familial and social construction of women's health revolves around her ability to perform her roles and duties. The concept of health for women is functional while the concept of illness is substantive. Women talk about health as a condition in which they can do their work well. Illness means when they have to meet a doctor. Health is social while illness is physical (Sharma et.al, 2002). So it was observed that health needs of women in India have a history of negligence. Women in India always being in a subservient role tend to neglect their physical and mental health. Whenever the question of health arises, it is always equated with reproductive health. Hardly, any attention has been given on the mental health needs of Indian woman.

Although Davar (1995a) points out that mental distress is more prevalent in women than in men, due to the social and religious stigmas attached to the women's personality, she faces a double bind situation where she sacrifices her own wishes and desires which often results in mental health problems. In the last three decades, with the changes in the social scenario, women have achieved an independent status and are now successful in almost all spheres of life. However, at the familial and societal levels, the woman in Indian defines herself relationally, even in the crisis situation. No matter, how much serious is her health concerns, her relational self dominates and she behaves accordingly Varma & Sahai, (2013).

In a traditional country like India, where role expectations from the women is the core factor in the development of family as a social unit, the status of the woman's mental health and factors underlying it should be seriously taken into consideration.

The research in the area of women's psychology has made an important attempt to focus on the mental health of women. The emergence of the women's movement and the upsurge of research on women since the late 1970's signalled the efforts to ensure mainstreaming of a gender perspective in all developmental processes *(National policy for the Empowerment of Women 2001)* and in social sciences in the academy (Sharma, 2003). In psychological research three main areas which received considerable attention by researchers are – work-family interface; violence against women; and mental health of women. In addition to these three areas, during the period 1993-2003, the psychological research also focused on the interface of reproductive health and psychological well being such as premenstrual distress, menopause, and pregnancy (Vindhya, U. 2007).

In a broad sense, mental health is a reflection of the equilibrium between the individual and the environment, constituting an integral part of overall health (World Health Organization, 2001a). With over 300 million people over the world suffering from mental health problems, and depression itself expected to be the second largest contributor to disease burden by 2020 (WHO 2001b), mental health is increasingly finding itself on the global radar of health hazards. Mental health is largely determined by multiple and interacting social, psychological and biological factors. Research has shown that mental illness is more common among people with some social disadvantage (Desjarlais et.al, 1995). Factors such as insecurity, hopelessness, violence, low income, limited education, abuse, physical ill health, distress, addiction, stressful work conditions and human rights violations have been found to increase vulnerability to mental health problems (Costello et.al 2003; Desjarlais et.al 1995; Parker et.al 2003; Patel et.al2003; Rutter, 2003).

Within the Indian context, since the 1960's through 1970's and the 1980's, several studies have been carried out to see the relationships between various demographical variables and mental illness. Research has established that mental illness is more common among women. A central characteristic of male dominated societies is that they implicitly define men as the norm, as standard human beings and women as 'other'.

The 'man' is equated with ' adult human' and 'woman' is considered as a special case, has meant that the study of women's health is restricted to obstetric and gynaecological. The psychology of women's health should encompass absolutely everything, which is relevant to the health of women. However, it cannot be concluded that women suffer mentally more than men do, but it is that women need special care because of their special problems and life situations.

A woman in India continues to be a provider of socio-emotional support rather than a receiver of such a support. Consequently marriage and family continue to be more supportive structures for men than women. The Indian men continue to be brought up and sustained by excessive sheltered universe of attachment, which breeds greater dependence characteristics in their personality. Thus support needs tend to be greater for men than women. It is expected that the denial of socio-emotional support to such men would have serious well being consequences as compared to Indian women, who seems to have developed internal psychosocial skills to cope with their peculiar life stresses. It must be emphasized that while societies depend so heavily on women for providing health care and buffers against stress, their own health or well being needs are frequently neglected.

Pattern and Prevalence of Mental Disorders among Women

There is evidence of greater prevalence of depression, somatoform and dissociative disorders in hospitals settings (Vindhya et al., **2001**); of somatic, anxiety and depression complaints among women in primary health care settings (Patel etal., 1999; Sachi Devi, 2003); and of a close association between reproductive illnesses such as gynaecological morbidity and common mental disorders among urban poor women in particular (Jaswal, 2001).

The greater prevalence of common mental disorders such as depression and somatoform disorders in women is linked to the impact of social circumstances on women's lives, a position that is at variance with the traditional intra-psychic approach to mental disorders. Thus discrimination in education, economic resources, legal and health services, the disproportionate burden of care-giving functions, and different forms of physical, psychological and sexual abuse across the life span is social factors that place women at greater risk of these disorders (Barnes, 1997; Davar, 1999).

Women, Role Conflicts & Mental Health:

With the globalization and consequent social change, the women started stepping out of their homes for financial reasons, for gaining a status in the society and for developing their hidden potentials. But this change placed her in more conflicting situations. The role of a working woman on one hand gives her a sense of economic security and independence but on the other hand, somewhere she is not comfortable in these conflicting roles demanding situations. These changes in the social scenario have in many ways increased the general vulnerability to mental health disturbances. Desai (1969) reported that different expectations of them and general role conflict result in stress and strain for most working women, the feelings of guilt arise out of a sense of neglecting their homes and families.

The effects of paid employment on several aspects of women's lives including on their families continue to be the most researched area. Study of the conflict between the domestic and worker roles in women had been one of the earliest topics of investigation related to women's lives in sociological research (Kapur, 1970) much before "women's issues" had gained attention. It is a fact that the area of paid employment of women continues to be the agenda of gender issues in psychological research in various universities and departments. This is primarily because the effects of paid employment on the lives of women and other family members are perceived as "women's problems" assuming that it is an offshoot of women's movement and hence it has to be handled by woman herself. There is comparatively paucity of research indicating the changes in the roles other family members as a result of women's employment. Else, it can be inferred that the percentage of this change in roles of other members of family is very less to be reported conclusively in the research studies. However, there is a need to look at such changes.

While the emerging women's studies literature has mainly focused on the characteristics of women's work, their situational analysis, technology associated problems, planning of development programmes, analysis of work force participation rates, and grappled with complexities such as conceptualization of women's economic activity, integration of women in the developmental process and the role of the state (Mukherjee, Sujaya & Jain, 1994), psychological research has continued to concentrate on comparisons with non-employed women, with the work-family linkages and the stressfulness and benefits of women's employment role.

However, with growing awareness for various career opportunities and a high need for achievement in the present social context women has a preference to work outside the house leading to an increase in the percentage of population of women in the paid employment. Therefore, in order to counterbalance the effects of role complexities it is very important to have a greater male participation in the "women's domain" i.e. household, children, and family.

Comparisons of Employed and Non-employed Women

Mental health consequences of employment of women have been investigated in several studies by comparing groups of women who are gainfully employed and those who are mainly engaged in domestic activities (Nathawat & Mathur, 1993; Mukhopadhyay, 1996; Saxena, 1996; Sharma & Panday, 1996; Sheela & Audinarayana, 1997; Singh, 1997; Sharma & Wellington, 1998; Bala, 1998; Gulati, 1998; Vasudeva & Choudhary, 1998; Aminabhavi & Kulkarni, 2000; Kumari & Singh, 2000; Mathur & Bharti, 2001; Aujla, 2002).

A few studies have shown significant mental health differences that favour employed women from middle and upper income groups vis-à-vis women who are not gainfully employed (Aminabhavi & Kulkarni, 2000; Vasudeva & Choudhary, 1998; Bala, 1998, Singh & Bawa, 1996; Kumari & Singh, 2000; Mukhopadhyay, Dewanji & Majumder, 1993). The authors conclude that the workplace offers benefits such as challenge, structure, self-esteem besides an increase in the family income; and emphasize the stressfulness of the housewife's role which often combines a high level of psychological demands with a low level of control.

In a study that reported findings contradictory to those cited earlier, Sharma and Panday (1996) showed working women to have higher levels of anxiety, fatigue, guilt, extraversion and arousal compared to housewives, while the latter were found to have greater depression. While the occupation of the employed group is not indicated, making it difficult to appreciate the validity of such comparisons, the rather strongly worded hypothesis states "Working women develop pathologies and increase their mental negativism than the non-working housewives". In fact the purported focus of the study is on "employment as psychological degenerator in women"! (p.3).

Saxena (1996) too reported that home environment provided greater life satisfaction among housewives. The marital and social adjustment of working women was found by Pandey (1996) to be unfavourably influenced by their employment status. Mukhopadhyay (1996) however did not find any significant physical and mental health differences between a group of urban middle class working mothers and non-employed mothers in Calcutta.

Comparing the psychosocial stress and perceived quality of life in non employed and working women (teachers), Dubey and Kumari (1999) found that higher psychosocial stress was significantly associated with poorer perception of quality of life in both working women and housewives. Although trust between marital partners were found to be a key correlate of marital adjustment in the case of working and non employed women of Hindu and Muslim groups, no such relation was significant in the case of Muslim housewives (Husain & Sharma, 1994). However the findings are discussed only in terms of personality variables and reflect a missed opportunity to situate the discussion of the findings in the context of impact of religious socialization on role expectations of marital partners.

In a comparison of stress management techniques used by employed women and housewives Aujla (2002) found that both groups adopted methods such as prayer, recreation, forming and maintaining interpersonal ties, proper house managements and setting priorities. However, working women tended to postpone certain tasks due to shortage of time and changing the level of job performance more frequently. Once again, the nature of work is not specified and the age range spanned nearly all the developmental phases of women's lives – from 18 to 60 years.

In a study on employment as determinant of psychological needs and values of unmarried women, Mathur and Bharti (2001) found that the need pattern of employed women and housewives were significantly different. While the employed group had higher achievement, autonomy and dominance needs, the housewives had greater deference, affiliation, nurturance, change and endurance needs. They were also found to have significantly higher religious values compared to the employed group. Autonomy was exercised in the important aspects of their lives such as Sheela and Audinarayana (1997) found that the work status of women before marriage and their educational status had a greater role in influencing the age at marriage.

Bharat (1994) compared the perceptions of career women in high paying jobs with those in low-level jobs and with the perceptions of their spouses on the desirable qualities of "Indian women". The career women and their spouses perceived both the traditional and non-traditional characteristics of Indian women as desirable. Sharma and Wellington (1998) explored the role expectation of couples where the wife was either employed or non employed. It was found that husbands of both categories of women expected the major share of domestic work including taking care of the children, housekeeping, entertainment and even religious activities should be performed by women while decisions related to financial matters were perceived as men's exclusive responsibility. The prevalence and dominance of such notions of gendered division of work and the social sanction posited a conflicting and demanding situation for women leading to serious mental health problems.

The difficulties women experience in juggling multiple roles and the ensuing mental health outcomes have been described and reviewed in both the feminist literature and mainstream social science literature (McBride, 1990). Parenting, transition to parenthood, work-related stress, presence of socially supportive network, and the variation in mental health conditions in the context of multiple roles are associated with competing demands which can lead to role overload and resulting strain (Agarwal, 1994; Kumar, 1994; Sahoo & Bidyadhar, 1994; Chowdhury, 1995; Krishnamurthi, 1996; Bidyadhar & Sahoo, 1997; Krishnaswamy & Kulkarni, 1997; Misra, 1998; Andrade, Postma & Abraham, 1999; Gupta & Sharma, 1999; Devi, 2000; Rani & Mishra, 2000; Rani & Yadav, 2000). Although most middle class Indian men and women in the post-Independence years have adopted combination of work and family as a life style, the two domains of work and family have been largely described as espousing conflicting values for women. Because most employed women also occupy family roles, assessment of the stressfulness and benefits of their employment role cannot be made in isolation. For women in particular, the quality of work life is linked to the quality of both marital and parent-child relationships. That work may serve as a buffer against stress arising from other roles is an insight gained primarily from studies of women's lives. The association between family role stress and negative health outcomes is typically found to be less strong in employed women compared to housewives, as reported, for example, in the landmark studies of Brown and Harris (1978). Indian studies however do not show such an unequivocal picture.

The relation of division of family task responsibilities to mental health outcomes has been investigated with some reporting that employment was associated with improved mental health only among those women whose husbands shared domestic work

Bidyadhar and Sahoo conducted a series of studies to explore the processes involved in the work-family linkage. In the first study, the subjective perceptions of working men and women regarding harmony and conflict inducing factors of the work-family relationship were studied (Sahoo & Bidyadhar, 1994). The researchers identified the harmony criteria as a) emotional support from spouse b) child-care facilities c) opportunities for recreation and relaxation d) help from neighbours e) adequacy of friends and f) clarity regarding division of responsibilities. The conflict-enhancing criteria were perceived as a) liabilities towards relatives b) temperamental differences between partners c) aspiration gap between the partners d) interference of family demands in work and e) interference of work demands in family. Emotional support from spouse, child-care facilities and clarity regarding division of responsibilities emerged as significant harmony-enhancing factors for both men and women. The conflict-inducing factors for both the groups were found to be temperamental differences. Men and women were found to significantly differ in one aspect only; it was women who emphasized lack of control to modify work schedules for family reasons and vice versa as predictors of conflict. It is pointed out that this lends support to earlier findings that women are significantly more susceptible to the effects of work-family stress. In line with the collectivist cultural orientation and the secondary status of women's employment role in the Indian context, the study did not find liabilities towards relatives and aspiration gap between the partners to be significant predictors of conflict.

Identifying the factors responsible for work and family involvement in married professional women, Bidyadhar and Sahoo (1997) found a positive relationship between child-care facilities and work involvement, and between spousal support and family involvement. Similarly, Asha (1994) found job satisfaction of women working in banks, and as school and university teachers to be related to their perception of family environment. Factors such as family support, independent decision-making, planning family activities tended to enhance women's job satisfaction. Lack of spousal support was found to be the strongest predictor of work-family conflict among women in a range of occupations and occupational levels (Misra, 1998).

In a comparison of working women with differing family roles, Asha (1992) found women with multiple roles in extended families experienced more anxiety and depression but less inferiority than did women with single or dual roles.

Although employed women, compared to non-employed women scored higher on depression, the type of marital coping strategies used threw up some differences between the two groups (Sarwar & Shah, 2003). In contrast to some earlier studies highlighting the detrimental effects of women's employment on marital relations, Sarwar and Shah report that employed women adopt constructive coping efforts such as open discussion of the problem with members of the family instead of avoidance and empowering methods such as refusal to take the entire blame for the marital problem.

Thakar and Misra (1999) demonstrated that social acceptance for women's employment is still not widely prevalent. They found employed women received less social support and consequently experienced more daily hassles compared to non employed women who received more social support and went through less daily hassles. Type of work done outside the home did not appear to be significant in structuring the experience of hassles. Conformity to traditional role by the housewives did not however lead to better well-being. The differences in well-being were attributed to use of problem focused coping by employed women.

In perhaps the only study that examined the mental health of mothers as mediated by place of residence and education, Chandra, Sudha, Subbarathna and Rao (1995) found slum women perceived their husbands as least supportive, younger and more educated women from higher income groups reported greater support, negative mental health outcomes were caused by family role demands such as disproportionate responsibility for housework and child rearing and husband support correlated positively with well-being in slum and urban women but less so in rural women.

The demographic factors related to work commitment of urban, educated working mothers employed in white collar jobs were found to be income, education and occupation while age, number of children, and type of family did not appear to play a significant role in work commitment (Gupta & Sharma, 1999). Krishnaswamy and Kulkarni (1997) examined the factors influencing anxiety of working women living in a hostel in Bangalore city.

It was found that women who had difficulties in commuting to work, were acutely conscious of their rural background and those who had lived in hostels during their student life expressed significantly higher levels of anxiety. The demographic correlates of anxiety were found to be age, education and income.

Sharma and Vohra (1998) found that the tradition-oriented conception of roles of husbands and wives was largely prevalent in the case of both single and dual earner couples. When ideological beliefs about sharing of household responsibilities were compared in single and dual career couples, Suppal, Roopnarine, Buesig and Bennett (1996) found that husbands and wives did not significantly differ in their perceptions but differences did emerge as a function of whether the family was extended or nuclear and whether the wife was employed outside the home.

In a study that reported findings contrary to the prevalent notion of traditional marital roles, Shukla and Gupta (1994) examined the relative salience of occupational, marital, parental and home care roles of dual earner couples and found that although these couples perceived the family roles (marital, parental and home) to be rewarding, they reported their involvement in these roles was minimal.

Therefore, looking at the trend of the research studies done in the area, it can be concluded that mental health problems due to role conflicts includes several moderating factors such as employment status, spousal support, personality factors of women herself, level of education and most importantly structural variables such as socioeconomic status and family structure.

Socio Demographic Relationships of Mental Disorders among Women

The socio-demographic profile of women who are most affected showed lack of formal education, being married, the occupations of housewife, daily wage or agricultural labourers to be the most significant predictors of mental health problems in women (Davar, 1999; Patel et al., 1999; Sachi Devi, 2003; Vindhya et al., 2001).

The association between reproductive illnesses such as gynaecological morbidity and common mental disorders among women of low-income groups in particular is high ,indicating a burden of both physical and mental illnesses among such women(Jaswal,2001).

The relationship between poverty ,women and common mental disorders has been attributed to the rising inequalities and deepening income disparities in the wake of economic reforms such as structural adjustment policies adopted currently in several developing countries(Patel et al.,1999 ; Sonpur and Kanpur,2001).

It is significant to note here that, despite the diversity in socioeconomic status of the affected women, a commonality in the mental health profile is evident. Amid the heterogeneity of class, caste and location differences among women, being female in a culture that devalues women may create a shared social experience and of mental health risks and outcomes.

Access to Mental Health Care

In contrast to the greater representation of male patients recorded from samples in psychiatric facilities, women have tended to predominate in community surveys(Davar,1999).More women have also been found to be seeking consultation from settings such as primary health care centres (Patel et al.,1999; Sachi Devi ,2003).

The gender gap in access to mental health care services is further compounded by the fact that the National Mental Policy (NMHP, introduced in 1982) is oriented towards the biomedical model to mental health, and as such prioritizes severe mental disorders such as psychoses, epilepsy and mental retardation for intervention. Therapies such as electrotherapy and chemotherapy that are more suited for such disorders are consequently the dominant modes of therapies in most psychiatric institutions. What this implies for women is that, first, the mental health policies espoused by the state are not oriented towards women's disorders and treatment needs are either taken care of at the level of the primary health care setting or are handled by alternative health systems, of which we have no systematic research, or are simply unmet.

Interventions and Suggestions

Gender biased attitudes towards mental health continue to be the bane for women even at the intervention stage, influencing the acceptance and treatment of psychological disorders.

In most conservative societies, social stigma attached to psychiatric morbidity, forcing women to continue either suffer silently or opt for alternative remedies rather than seeking professional help (Basu S. 2012). Often, women in emotional distress end up being labelled as "witches" or as acting under the influence of "spirits" and are treated accordingly (Boddy, 1989; Davis and Low, 1989; Kakar,1982; Lewis, 1986; Pang, 1994). Rather than recognising the distress signals of women suffering with mental health problems, even today, Indian women, especially in rural areas, are forced to take up alternate sources of treatment from local witch doctors, quacks or religious practitioners, further aggravating their psychological ill health. An appropriate recent event that can be quoted here is the act of barbarity against women was clicked by Hindustan Times newspaper at Sangam city, Allahabad in the "auspicious" month of *Magh* on 22nd February, 2014. In front of a good number of onlookers, a number of women supposedly from Banda district in Uttar Pradesh were brought in two vehicles by a dozen men. One by one, these women were caught by the hair dragged inside the "*holy waters*" of Sangam and beaten with iron chains after a forced dip into the water. Research has established that prevalence of mental disorders is more in women, however access to mental health services are more by men. Who is responsible for this discrepancy? The answer lies with women herself, the family in which she lives, the stigma attached to the madness and yes of course with the general attitude of people to give last preference to their mental health needs. As a researcher in women's studies and psychology, it becomes the first priority to critically evaluate these factors and look for the prospects.

Mental health problems are major silent epidemic; and are graver in the case of women. Therefore there is a need to outline some of the suggestions in order to treat women's mental health problems in a more sensitive manner. These suggestions are-

1. Developing a mental health awareness programme for women. Government of India successfully eradicated polio and to a greater extent implemented programmes on developing awareness for issues related to reproductive health such as (RTI, AIDS etc.); the issue of mental health should not be left out and shall be addressed by starting effective policies.

2. Developing awareness will help in early detection of mental health problems and hence can be solved at an early stage by psychological counsellors. As the culture of *Aanganwadi* has successfully helped in resolving reproductive health problems,

similarly some steps shall be taken so that early symptoms like headaches, anxiety, sleeplessness, fatigue, pain in shoulders and back etc can be easily addressed to.

3. Understanding the psychosocial and socio cultural causes of women's mental health problems. This can be achieved by employing more and more psychological counsellors who can help women with counselling sessions in the very beginning of the disorders and hence interventions can be started and will be more successful

4. Developing a gender sensitive approach - gender sensitization of society involves addressing gender discrimination by encouraging people to have a gender free perspective towards others. This can help in mainstreaming women's issues and reducing "male streaming" in mental health also.

5. There shall be some legal checks regarding rehabilitation and reabsorbing of female members back in the family. " Fighting the Taboo"

6. Women need to be empowered. Different sections of women have their different empowering needs. So the woman's need to take a decision and live their lives fully shall be achieved. For e.g. Developing more and more self help groups (SHG) in economically weaker groups of women.

7. There is lot of research done in the area of women empowerment. There is a need to develop a strong linkage between research and poicy. Researches and studies are left with a handful of people who are working in the academics. Policies should focus on taking these researches to the people who need it most.

References

Adler, N., Boyce, T., Chesney, M.A., Cohen, S., Folkman, S., Kahn, R.L., & Syme, S.L. (1994). Socioeconomic status and health: The challenge of the gradient. *American Psychologist, 49*(1), 15–24.

Agarwal, V. (1994). Stress and multiple roles in women. *Indian Journal of Social Science, 7* (3 & 4), 319-333.

Aminabhavi, V.A., & Kulkarni, V.R. (2000). Mental health of working women and housewives. *Praachi Journal of Psycho-Cultural Dimensions, 16* (1), 33-35.

Andrade, C., Postma, K., & Abraham, K. (1999). Influence of women's work status on the well-being of Indian couples. *International Journal of Social Psychiatry, 45* (10), 65-75.

Asha, C.B. (1992). Multiple roles and mental health status of working women. *Journal of Community Guidance and Research, 9* (2), 181-188.

Aujla, H.P. (2002). Mental stress management techniques: An analysis among working and non-working women. *Behavioural Scientist, 3* (2), 125-127.

Bala, M. (1998). Social self-concept of educated employed and educated unemployed women. *International Journal of Social Psychiatry, 44* (1), 71-74.

Barnes, B.L. (1997) 'Mental Health Issues in Young Females: A Gender Perspective', *Bombay Psychologist* 14(2): 37–45.

Bharat, S. (1994). Perception of Indian women: A comparison of career and non career women. *Psychologia, 37*, 18-30.

Bharat, S. (1994). Perception of Indian women: A comparison of career and non career women. *Psychologia, 37*, 18-30.

Bharathi, G. (2000). Mother: Perceptions of sons and daughters. *Osmania Journal of Psychology, 25*, 63-66.

Bidyadhar, S., & Sahoo, F.M. (1997). Psychological factors of work-family linkage. *Psychological Studies, 42* (2 & 3), 49-60.

Boddy, J. (1989). *Wombs and alien spirits: Women, men and the Zar cult in*

Brown, G.W. (1998). Genetic and population perspectives on life events and depression. *Social Psychiatry and Psychiatric Epidemiology, 33*(8), 363–372.

Chandra, P.S., Sudha, M.B., Subbaratna, A.R., Rao, S. (!995). Mental health in mothers from a transitional society: The role of spouse supportiveness. *Family Therapy, 22* (1), 49-59.

Chandrashekar CR ,Issac MK , Kapur RL,Parthasarthy R.Management of priority mental disorders in the community. Indian J Psychiatry1981;23:174-8.

Chowdhury, A. (1995). Employed mothers and their families in India. *Early Child Development and Care, 113*, 65-75.

Davar, B.V. (1995) 'Mental Illness in Indian Women', *Economic and Political Weekly*   30(45): 2879–86.

Davar, B.V. (1999) *Mental Health of Indian Women: A Feminist Agenda.* New Delhi: Sage.

Davar, B.V. (ed.) (2001) *Mental Health from a Gender Perspective.* New Delhi: Sage.

Davis, D.L., & Low, S.M. (Eds). (1989). *Gender, health and illness: The case of* Indian Council of Medical Research- Department of Science and Technology (ICMR-DST). A collaborative study of severe mental morbidity. New Delhi: ICMR; 1987.

Desjarlais, R., Kleinman, A., Eisenberg, L., & Good, B. (Eds). (1995). *World*

Devi, G.N. (2000). The dual role of married working women in the changing scenario of Indian society. *Journal of Community Guidance and Research, 17* (3), 325-333.

Dubey, A., & Kumari, V. (1999). Psychosocial stress and perceived quality of life in working and non-working women. *Indian Journal of Psychological Issues, 7* (2), 63-66.

Gautam S. Development and evaluation of training programmes for primary mental health care. Indian J Psychiatry1985;27:51-62.

Gulati, J.K. (1998). Father child interaction in working and non-working mothers' families. *Indian Journal of Psychometry and Education, 29* (2), 139-142.

Husain, A., & Sharma, T. (1994). Marital adjustment and its correlates among working-non-working women, *Journal of Personality and Clinical Studies, 10* (1-2), 71-75.

Issac MK ,Kapur RL,Chandrashekar CR,Kapur M, Parthasarathy P. Mental health delivery through rural primary care-Development and evaluation of a training programme. Indian J Psychiatry 1982;24:131-8.

Issac MK, Chandrashekar CR, Srinivasa Murthy R, Kapur BV .Decentralised training for PHC medical officers of a district. The Bellary approach In Verghese A (ed). Continuing medical ducation , Vol VI. Calcutta:Indian Psyciaric Society;1986.

Kakar, S. (1982). *Shamans, mystics and doctors: A psychological inquiry into India and its healing traditions.* New York: Knopf.

Kapur RL, Chandrashekar CR, Shamasundar C, Issac MK,Parthasarathy R, Shetty S. Extension of mental health service through psychiatric camps: A new approach. Indian J Psychiatry 1982;24:237-41.

Krishnaswamy, S., & Kulkarni, L.V. (1997). Factors influencing anxiety of working women hostelers of Bangalore city. *The Indian Journal of Social Work, 58* (1), 1-12.

Krisnamurthi, L. (1996). Role conflicts and tensions of women police criminal justice administration. *Indian Journal of Social Work, 57*(4), 614-629.

Kuh, D., Hardy, R., Rodgers, B., & Wadsworth, M.E. (2002). Lifetime risk factors for women's psychological distress in midlife. *Social Science andMedicine, 55*(11), 1957–1973.

Kumari, P., & Singh, A.P. (2000). Life stress and some personality variables: A comparison of working women and housewives. *Journal of the Indian Academy of Applied Psychology, 26* (1-2), 25-31.

Lewis, I.M. (1986). *Religion in context: Cults and charismas.* Cambridge: Cambridge University Press.

Macran, S., Clarke, L., & Joshi, H. (1996). Women's health: Dimensions and differentials. *Social Science and Medicine, 42*(9), 1203–1216.

Marmot, M. (2003). Self-esteem and health. *British Medical Journal, 327*(7415),

Mathur, P., & Bharti, S. (2001). Employment as determinant of psychological needs and value of unmarried females. *Psycho-Lingua, 31* (2), 99-102. *Medicine, 55*(11), 1957–1973. *mental health: Problems, priorities and responses in low-income countries.*

Ministry of Health and Family Welfare ,Government of India.National Health Policy,2000.

Ministry of Health and Family Welfare,Government of India.Annual Report to the People on Health.New Delhi: Ministry of Health and Family Welfare, Government of India ;September 2010.

Misra, P. (1998). Predictors of work-family conflict among Indian women. *Indian Journal of Clinical Psychology, 25* (1), 13-19.

Mukhopadyay, P. (1994). A psychological evaluation of amenorrhic cases. *Indian Journal of Psychological Issues, 2* (2), 16-19.

Mukhopadyay, S. (1996). Working status and health: A study of middle class Calcutta women. *The Indian Journal of Social Work, 57* (2), 327-336.

Mukhopadyay, S., Dewanji, A., & Majumdar, P.P. (1993). Working status and anxiety levels of urban educated women in Calcutta. *International Journal of Social Psychiatry, 39* (3), 200-207.

Murthy RS, Kala R, Wig NN. Mentally ill in a rural community: Some initial experiences in case identification and management.Indian J Psychiatry 1978;20:143-7.

Nathawat, S.S., & Mathur, A. (1993). Marital adjustment and subjective well-being in Indian educated housewives and working women. *Journal of Psychology, 127* (3), *353-358.*

Pandey, M. (1996). Professionalism vs. socialism: A study of women employment. *Indian Journal of Psychometry and Education, 27* (2), 77-80.

Pang, K.Y.C. (1994). Understanding depression among elderly Korean immigrants

Parkar, S.R., Fernandes, J., & Weiss, M.J. (2003). Contextualising mental health:

Patel V, Thara R (eds). Meeting mental health needs in developing countries: NGO innovations in India.New Delhi: Sage (India);2003.

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in

Patel, V., Araya, R., de Lima, M., Ludermir, A. and Todd, C. (1999) 'Women, Poverty and Common Mental Disorders in Four Restructuring Societies', *Social Science and Medicine* 49(3): 1461–71.

Piccinelli, M., & Wilkinson, G. (2000). Gender differences in depression. *The* poverty and common mental disorders in four restructuring societies. *Social*

Ranganathan S. The empowered paradigm community: A paradigm community in the treatment of alcoholism. Madras: TTR Clinical Research Foundation; 1996.

Rani, D.L., & Mishra, P.K. (2000). Coping behaviour among working women in emergency services. *Social Science Interantional, 16* (1-2), 33-51.

Rao, V. (1997). Wife-beating in rural south India: A qualitative and econometric

Rutter, M. (2003). Poverty and child mental health: Natural experiments

Sachi Devi, K. (2003) 'Common Mental Disorders in Primary Health Care Settings: A Study of Socio Demographic Correlates', unpublished doctoral dissertation, Andhra University, Visakhapatnam, India.

Sahoo, F.M., & Bidyadhar, S. (1994). Critical factors of work-family linkage: An application of lens model to generate indigenous dimensions. *Psychology and Developing Societies, 6* (2), 169-185.

Sarwar, A., & Shah, A.A. (2003). Marital coping and depression among employed and non-employed women. *Personality Study and Group Behaviour, 23*, 45-60.

Saxena, M.R. (1996). Life satisfaction and perceived happiness as a function of family structure and employment of women. *Indian Journal of Psychometry and Education, 27* (1), 41-46.

Sharma, K. (2003) 'Institutionalizing Feminist Agenda(s)', *Economic and Political Weekly* 38(24): 4564–6.

Sharma, K.N. & Panday, M. (1996). Women employment as psychological degenerator. *Praachi Journal of Psycho-cultural Dimensions, 12* (1), 3-6.

Sharma, N., & Wellington, M. (1998). Role of expectations of couples with employed and non-employed wives, *Praachi Journal of Psycho-Cultural Dimensions, 14* (1), 33-37.

Sharma, S., & Vohra, S.S. (1998). Roles, role expectations and role strain in couples and patterns in their marital adjustments. *Journal of Research and Applications in Clinical Psychology, 1* (1), 50-64.

Sheela, J., & Audinarayana, N. (1997). Work status of women and age at marriage in Coimbatore city: A multivariate analysis. *The Indian Journal of Social Work, 58* (1), 78-89.

Shukla, A., & Gupta N. (1994). Salience of occupational, marital, parental and home care roles and its personality correlates: A study of dual career couples. *Psychological Studies, 39* (2 & 3), 99-103.

Singh, A., & Bawa, S.K. (1996). Adjustment problems of working women. *Praachi Journal of Psycho-Cultural Dimensions, 12* (1), 15-20.

Singh, B. (1997). Anxiety among working and non-working women, *Praachi Journal of Psycho-Cultural Dimensions, 13* (2), 105-108.

Sonpar, S. and Kapur, R. (2001) 'Non-conventional Indicators: Gender Disparities under Structural Reforms', *Economic and Political Weekly* 42(2): 66–7 8.

Srinivas Murthy R., Wig NN. Evaluation of the progress in mental health in India since Independence. In: Mane P, Gandevia K. (eds) Mental health in India: Issues and concerns. Bombay, Tata Institute of Social Sciences: 1993; 387-405.

Srinivasa Murthy R. Community mental health in India. In: Mental Health in India-Essays in honour of Prof. N.N Wig Bangalore: peoples Acion for Mental Health;2000:150-76.

Srinivasa Murthy R. Family and mental health care in India. Alumni J Christian Medical College 2007;41:19-30.

Stansfield, S.A., Head, J., & Marmot, M.G. (1998). Explaining social class differentials in depression and well-being. *Social Psychiatry and Psychiatric Epidemiology, 33*(1), 1–9.

Suppal, P.G., Roopnarine, J.L., Buseig, T., & Bennett, A. (1996). Ideological beliefs about family practices: Contemporary perspectives among north Indian families. *International Journal of Psychology, 31* (1), 29-37.

Thakar, G., & Misra, G. (1999). Job and well-being: The experiences of employed women. In G. Misra (Ed.), *Psychological Perspectives on Stress and Health.* New Delhi: Concept.

Vidyasagar.Challenge of our times: Presidential Address.(1973) Indian Journal of Psychiatry 1973;15:95-103

Vindhya, U., Kiranmayi, A. and Vijayalakshmi, V. (2001) 'Women in Psychological Distress: Evidence from a Hospital-based Study', *Economic and Political Weekly* 36(25): 4081–7.

Wig NN, Srinivasa Murthy R, Harding TW. A model for rural psychiatric services- Raipur Rani experience. Indian J Psychiatry 1981;23:275-90.

Wig NN. General hospital psychiatric unit-right time for evaluation.Indian J Psychiatry 1978;20:1-9.

World Health Organization (WHO). (2001a). *Strengthening mental health promotion.*

World Health Organization (WHO). (2001b). *Mental health: New understanding, new hope.*