

Struggles of Women with Mental illness

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Abstract: *Women are integral to all aspects of society. However, the multiple roles that they fulfill in society render them at greater risk of experiencing mental problems than others in the community. Women living in poor social and environmental circumstances with associated low education, low income and difficult family and marital relationships, are much more likely than other women to suffer from mental disorders. Women's mental health needs to be considered in the context of social, political and economic realities. While there exists a huge gap between availability and accessibility of the health care services, various social, legal and ethical issues especially in respect of women with mental illness act as hindrance in the overall care and recovery of such women. A gender-based, social model of health needs to be adopted to investigate critical determinants of women's mental health with the overall objective of contributing to improved, more effective promotion of women's mental health.*

Keywords: *discrimination, homelessness, victimization .*

I. Introduction

Mental health may be defined as the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective well-being, optimal development, and the use of cognitive, affective and relational abilities^[1]. It is much more than the absence of mental illness.

Mental health is recognized globally as being of enormous social and public health importance. Mental health problems currently are said to constitute about eight per cent of the global burden of disease and more than 15 per cent of adults in developing societies are estimated to suffer from mental illness. According to the new concept of measuring disability called Disability Adjusted Life Years (DALY), mental disorders constitute a significant part of total disability adjusted life years (8.1%), more than the disability caused by several well recognized disorders such as cancer (5.8%) and heart diseases-(4.4%),^[2]. Mental health is also recognized as having economic importance, with the economic consequences of mental ill-health predicted to be dire on account of lost productivity and the upfront costs of treating those afflicted.

People suffering from mental illness and other mental health problems are among the most stigmatized, discriminated against, marginalized, disadvantaged and vulnerable members of society^[1]. Mental ill-health and its profound stigmatization carry with it a burden of human suffering that at times is not only incalculable, but incomprehensible to the non afflicted onlookers^[3]. The situation can be much worse if the affected person is woman. Both community surveys and hospital-based studies indicate that women are disproportionately affected by mental health problems and that their vulnerability is closely associated with their marital status, work and roles in society.

Women's mental health cannot be considered in isolation from social, political and economic issues. Examination of women's position in society reveals that there are sufficient causes in current social arrangements to account for the surfeit of depression, anxiety and distress experienced by women. Consideration of women's mental health therefore requires recognition of the impact of social factors on mental health, a position that challenges traditional biomedical approaches to mental illness^[2].

Women across cultures have been experiencing denial of economic resources, education, legal and health services, poor physical and mental nurturance, exhaustion from overwork or sexual and other forms of physical and mental abuse across their life span. In addition, the routine of women's lives render them at risk to experience more stress than men. This reflects the greater number of social roles women fulfill as wife, mother, daughter, care-giver and an employee. Furthermore, women's reproductive role as bearer and nurturer of children and the varied roles, produce unique potential for stress related effects^[3].

Setting: The Institute of Human Behaviour and Allied Sciences, at Delhi, India is a multi disciplinary institute which provides tertiary level services with a mix of primary and secondary care. It is observed that almost 40-45% of the patient population of the institute is women and nearly 50% of women inpatient population care through reception order. Such admissions are of those persons who are found wandering on the streets or picked up by police whose identity is almost not known. The multidisciplinary teams of IHBAS provide clinical and

specialized service at optimal level. However, when these women are adequately treated and are found fit for discharge reintegrating them back into society is a big challenge. However, at IHBAS we have been quite successful in reintegrating and rehabilitating those brought in for treatment from the streets by exploring various options and networking with various government and non government organizations.

II. Method

Case 1

A 30 year old Ms. D had been on treatment for her chronic mental illness since more than five years. During this period, she had a broken marriage and loss of a child. She was admitted with yet another exacerbation when treating team at IHBAS realized that she was pregnant after being sexually exploited by her brother in law who was also the caretaker of the patient after her father's death. Moreover he had even taken the patient's signature for transfer of the property on his name during her partial recovery state. Despite repeated promises by the family to take care of the patient, she was left to fend for herself and her child, whom she delivered at the hospital. None of the shelter homes for women in the city were willing to accept Ms. D along with the child. However, with the help of an NGO Ashray Adhikar Abhiyaan, the treating team was able to find a place for Ms. D in the shelter home. Here too, due to irregular medications, patient's condition deteriorated. As the NGO was an open shelter home, Ms. D left the shelter home on a number of occasions and was again sexually and physically exploited repeatedly on her numerous such visits. She even lost her child she had cared so much for and had to live with a major physical disability caused due to a road traffic accident. Ms. D is now a bed ridden inmate in one of the shelter homes with nothing to look forward to.

Case 2

Mrs. I, a village girl from the state of Jammu and Kashmir in India, was diagnosed as Bipolar Affective disorder at the age of 14. She had been on treatment since then though irregularly. Due to the instability in the region she was married off at 15 years of age. Parents had not revealed about her illness to her husband due the stigma of the illness. After marriage all the medicines were automatically stopped. Mrs. I again had her manic symptoms in the form of dis-inhibited behavior, over spending, dressing up well etc. which were considered as highly immoral by her husband and in-laws and she was regularly beaten by them. Mrs. I would often run to her parents for support but would be asked to return to her husband. On one such occasion Mrs. I left her husband's house and boarded the train to Delhi. On her way she had been assaulted sexually and physically multiple times by the men unknown to her. She finally landed in IHBAS hospital, as per the Reception order. After the treatment, the patient recovered completely. The treating team could finally get her parent's whereabouts and contacted them but they refused to visit the hospital or take her back. However, upon several attempts by the treating Social worker at educating and, persuading the parents, they came. Ms. I has now gone back to her parents place with agreement to continue treatment from the Government hospital in Jammu.

Case 3

Ms. C, a 38 year old unmarried lady was brought to IHBAS hospital, Delhi through Metropolitan Magistrate order. She was treated for psychosis and during her recovery phase she gave complete address. She belonged to a village on Delhi-Haryana border. After the death of her parents she was staying with her nephew. She reported she had some agricultural land which helped her to maintain her daily living. Despite two home visits and counseling by treating team patient's family refused to accept her on account of their own limitations and difficulties. The village leader (Sarpanch) was then contacted along with the local community leaders. With the active participation of the Village Panchayat, the matter was amicably solved. It was mutually decided that one of the brothers of the patient would take her responsibility and her maintenance cost would be borne from the income generated from her land.

Case 4

In the silence of dark, Ms. G was crying bitterly in distress. She was finding the icy winds unbearable and she did not even have warm clothes on her body. Since the cold was killing her, she got up to walk around to generate some warmth in her body. At around midnight, the local goons roaming around that area found her gave some clothes to wear, which she accepted. She did not know that all this is not free. She would have to pay for it. They took her to some restaurant, gave her food. With warm clothes on the body, food in the tummy, Ms. G felt better. Now she could talk. Taking advantage, the boys asked her to accompany them to a shelter where she could stay for the night. She was taken to a dark lane, where she got raped by them. That was the beginning of her ordeal on the street. She never got to know of a place where she could feel herself safe. With the passage of time she accepted her fate. Whatever she got from devotees or passersby, she ate or else lie down there. People passed by, police patrolled that area. Probably she remained invisible to all of them. Till one day, some social workers on the field duty saw her pitiable condition; after involving the police, she was admitted in the

hospital with fractured arm and high fever. On recovery police forgot the case; she was brought to shelter run by NGO. Once she recovered fully, she expressed her desire to go back, and she was sent back to her family. (Later, on a follow up visit we found that she again left home. Family did not bother to know about her whereabouts).

III. Discussion

These Case studies bring us to the crucial issue of hardships encountered, the neglect faced and the rights denied of several women who have suffered a mental illness. Acceptance of these women back into their once 'loving' homes and ensuring them good care and support from the family, getting them their due, be it their dignity or respect, or even their own share in the property becomes an arduous and mostly unsuccessful effort by those involved in their comprehensive treatment and care, especially their tertiary care support providers.

With inadequate support and a strong gender bias, the mentally ill women are rarely accepted into the family and are forced to fend for themselves resulting in homelessness. For many women, homelessness follows years of violence and abuse which undermines their self esteem, contributes to the pain of powerlessness, and reinforces the social invisibility of their lives^[4]. Persons with mental illness are over-represented among the homeless relative to the general population, and mental illness is most likely one of the many vulnerabilities that confer risk for homelessness^[5]. Mental illness may play a role in initiating homelessness for some. A combination of severe mental illness, a tendency to decompensate in a non structured environment, and an inability or unwillingness to follow through with aftercare contributes to their being involved with the criminal justice system.

Physical Abuse and Abandonment

Passive violation in the form of neglect by families is far more than noted. Incidences of active violation include physical, mental as well as sexual abuse. Mentally ill women are commonly and repetitively abused with rape and other sexual assaults, as well as physical violence. The regular forms of trauma, domestic violence, sexual abuse, vulnerability, stigma and victimization faced by women also have an impact on the mental health^{[6][7]}.

Inexplicably, society has a very unforgiving attitude towards the mentally ill women, as though they themselves are responsible for their plight. In many instances the perpetrators are their own family members. Women who face family violence and other forms of victimization, such as abuse by their family of origin are often fleeing from their homes to end up being homeless^[8].

Human rights violation through chaining/ locking, though common, could be also due to ignorance and helplessness on the part of the family members. Consultation with the mental health professionals for the female members of the family is less often than that noted for the male counterparts.

As quoted, "Discarded by families or wandering further and further away from home, their real selves are lost or submerged under layers of dirt and idiosyncrasies- handicaps both primary and secondary. They become non-persons, consciously ignored or worse, paid unhealthy attention. Women are particularly prone being easy targets of sexual abuse. The mentally ill destitute comprise a largely forgotten and unthought-of section of the homeless"^[9].

Poor Access to Health Care Facilities

The help seeking and utilization of the existing treatment services by women with mental illnesses is still low despite increasing awareness regarding mental illnesses. A woman with mental illness, though of a severe degree is not brought for treatment in the early stages in comparison to her male counterpart. A married woman, who is ill, loses the support of the husband and his family and is sent to her parent's house, where she would be at the mercy of helpless parents, brothers and sisters-in-law. Sometimes, even the treatment is denied to her by the husband who is the lawful guardian. The mental illness makes the woman incapable of asking for help herself.

Once engaged in the treatment, maintaining them in the treatment may become difficult in the absence of adequate social support. The contacts with the doctors are often in emergency services with no follow up ever maintained. Neglect leading to abandonment and thereby homelessness is one of the common outcomes in these women.

One tragic aspect is that families admit their mentally sick members to homes and asylums by providing false address. Many of those who recover are not accepted back by the family and therefore, the cured patients have no option but to continue to stay at the hospitals wherein they are admitted who provide shelter on humanitarian grounds.

Homelessness

Homelessness has been debated as the cause as well as consequence of mental illness and disability. Women are becoming the fastest growing segment of the homeless population. For many women, homelessness follows years of violence and abuse which undermines their self esteem, contributes to the pain of powerlessness, and reinforces the social invisibility of their lives ^[4]. The multiple implications and the magnitude of the problem, call for an urgent attention, of all the service providers and policy makers. An attempt is made here to highlight some of the dilemmas and difficulties encountered along with certain case studies providing a glimpse into the lives of women with mental illness.

In a study with the homeless population ^[10] 91% were diagnosed to be suffering from primary psychiatric illness with about 40% having psychosis and 29% having substance use disorder. For many mentally ill women, homelessness leads to years of violence and abuse which undermines their self esteem, pain of powerlessness and reinforces the social invisibility of their lives. Access to basic health care services as well as mental health services due to the homeless status and mental illness is very poor. In a majority of cases the mentally ill women suffer from fractures, dog bites or other major physical health problems. Upon treatment and subsequent recovery, non-acceptance of the woman by the family, lack of welfare centers in the community push her back to homelessness where the treatment would discontinue.

Legal rights versus mental illness

Mental illness, irrespective of the severity, has often been cited as one of the reasons that deprive a woman of her basic human and civil rights. They often knowingly or unknowingly continue to be marginalized, invalidated, violated and/or ignored. The basic human rights with respect to individuals survival with dignity has to be ensured in all situations as stated in the constitution; but the scenario in case of mentally ill woman is still far from optimal.

As per the law, a person with mental illness cannot sign any document of sale, purchase, lease or any contract. However, the rights are not clear as to an individual's competence during the lucid moments/stabilized stage. In normal circumstances too women face difficulties in exercising their rights but in such instances family members may take undue advantage of this clause to deny the property rights to mentally ill woman.

While it is clearly stated by law that persons with mental illness have the right to live with dignity, in reality, many women with mental illness have been robbed of personal dignity repeatedly. The fundamental rights of fulfillment of the basic needs, right to shelter, right to safety, right on one's own body including right to reproduction as well as the social rights need are rarely protected in the case of mentally ill women.

The issue of mental (ill) health, and more specifically its profound ethical dimensions, affects us all. The suffering of those with a mental health problem is a reality which we, either as individuals, members of a (professional) group, or members of a given community, cannot ignore, at least not ethically. We should not be indifferent to their suffering ^[11]. To ignore or to be indifferent to such profound human suffering would be to abandon those in distress and to compound their vulnerability in morally unacceptable and culpable ways. We must not abandon the mentally ill and leave them languishing on the margins of community, of humanity.

IV. Conclusion

Women's mental health must be considered within the context of women's lives and cannot be achieved without equal access to basic human rights: autonomy of the persons, education, safety, economic security, property and legal rights, employment, physical health including sexual and reproductive rights, access to health care and adequate food, water and shelter. Women's mental health requires the elimination of violence and discrimination based on sex, age, income, race, ethnic background, sexual orientation or religious beliefs. While both sexes benefit from the above factors and the overall rates of mental illness are similar in men and women, women's unique roles in reproduction, the family and society, their often lower socio-economic status, necessitate special considerations for their mental health.

As responsible mental health professionals and citizens, it is our duty to promote and protect the well-being and welfare of persons at risk of harm due to their mental disorders and other mental health problems and correct the 'wrong' conduct and promote the 'right' conduct of the persons around towards those with mental health problems.

It is imperative that when we make legal care accessible to persons who are mentally ill, we need to define a clearer frame work of execution of the rights, benefits and privileges guaranteed to them. Certainly, initiatives aimed at educating the public, promoting mental health through mainstream health promotion activities, establishing preventative mental health programs as an essential component of care provision to people at risk of mental health problems, and promoting research, are all essential to promoting better mental health outcomes. If the stigma attached to mental illness and other mental health problems are addressed appropriately, we could dream of a compassionate society genuinely promoting realization of social justice, equity, access and rights to persons with mental illnesses.

References

- [1]. Johnstone MJ. Stigma, social justice and the rights of the mentally ill: Challenging the status quo; Australian and New Zealand Journal of Mental Health Nursing, 2001;10,200-09
- [2]. Vindhya U. Mental Health Care: A Review of Gender Differences, International Journal of Diabetes in Developing Countries 2001; 21:86-96
- [3]. Kanchan Kumari (2008): Women and children: mental health dimensions. In Nagaraja D & Murthy, Pratima (Eds): Mental Health Care and Human Rights, 234-242, NHRC, New Delhi.
- [4]. National Commission for Women Report (2007). http://ncw.nic.in/PDFFiles/Mental_health_is_destitution_the_only_answer.pdf
- [5]. Sullivan,G., Burnam A., Koegel,P.Pathways to homelessness among the mentally ill. Social Psychiatry Psychiatr Epidemiol, 2000, 35 (10), 444-450. <http://www.ncbi.nlm.nih.gov/pubmed/11127718>
- [6]. Kumar S, Jeyaseelan L, Suresh S, Ahuja RC. Domestic violence and its mental health correlates in Indian women. The British Journal of Psychiatry 2005; 187: 62-67. 5.
- [7]. Chandra P, Carey MP, Carey KB, Shalininananta A, Thomas T. Sexual coercion and abuse among women with a severe mental illness in India: an exploratory investigation. Comprehensive Psychiatry 2003; 44, (3): 205-212.
- [8]. Montgomery, Carol RN (1994), Swimming Upstream: The strengths of women who survive homelessness. Advances of Nursing Science, 16(3).
http://journals.lww.com/advancesinnursingscience/Abstract/1994/03000/Swimming_upstream_The_strengths_of_women_who.6.aspx
- [9]. Kendra (2002). Out of Mind, Out of Sight- Voices of Homeless Mentally Ill. East West Books (Madras) Pvt. Ltd.2002
- [10]. Bassuk, E.L., Buckner, J.C., Perloff, J.N., and Bassuk, S.S. (1998). Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. American Journal of Psychiatry, 155, 1561-1564.
- [11]. Nagel, T. (1979) Mortal Questions. Cambridge University Press, New York