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PLATINUM JUBILEE CELEBRATION 1968 – 2023
Indian Psychiatric Society Publication

Women's Mental Health

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2 CHAPTER

Severe Psychiatric Illness in Women: Rehabilitation and Recovery

Ramachandran Padmavati, Mangala Ramamurthi, Arthi R

ABSTRACT

This chapter provides some insights on gender-specific psychosocial intervention for women with serious mental illnesses (SMI). Literature review reveals the paucity of literature pertaining to women-centric approaches. However, the need for taking into account the needs of women in any psychosocial intervention is quite relevant. The impact of these gender-specific interventions needs more robust testing. The relevance of technology in the delivery of interventions also needs gender-specific interventions.

Keywords: Women centric approaches, psychosocial rehabilitation, severe mental illness

INTRODUCTION

Gender is an important element of mental health and mental illness. Women with a diagnosis of serious mental illnesses (SMI) are often doubly disadvantaged. Several gender-related structural factors like limited opportunities interpersonal violence, lack of social supports, poverty, and gender biases in mental health practice reduce accessibility to mental health services or keep the women living with SMI in psychiatric institutions. In contrast to conditions like depression or anxiety, the prevalence rates of schizophrenia and bipolar disorder do not show marked gender differences.[1,2]

Male and female gender vary with respect to age of onset, occurrence of psychotic symptoms, course and outcome of illness, and social functioning. Women with SMI demonstrate more affective symptoms, like depression, impulsivity, emotional instability, and sexual delusions as compared to men, who are at a greater risk of prominent negative symptoms.[3] Women with bipolar disorders present with a first episode of depression, higher frequency episodes of depression, "rapid cycling", and a higher comorbidity of hypothyroidism, migraine, and obesity.[4]

Although many studies, in developing countries have shown that female gender did better than men with respect to course and outcome of schizophrenia, recent studies have not demonstrated any gender difference.[5,6] There is a discrepancy between prevalence, access to and utilization of services, with more men accessing services than women. This is partially explained by the limited number of beds for women in the hospital settings. In a study of allotment of beds, only about a third of the beds were allocated for women.[7] The mental hospitals appear to provide services for men in distress.[7]

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Despite the fact that rehabilitation in mental health within the framework of recovery, has been incorporated by many services across the world, in the context of gender, recovery and rehab need to viewed differentially.

The implication of Anthony's[8] widely used definition of recovery is that it is an individualized process. There is mounting evidence that supports the value of psychosocial interventions to address mental ill-health, especially in low- and middle-income settings.[9,10] It has been observed that little attention has been paid to the special needs of women in psychosocial rehabilitation (PSR) programs. Social implications such as desertion by marital families, sexual abuse, infectious diseases, and homelessness contribute to the difficulties of rehabilitation of women.[11] In addition to the family hierarchy and the consequent limitations in decision-making about their own lives, women face other forms of woman-specific discrimination, limits to healthcare access, education, and economic independence, and restrictive role delineation as carers of others in the family.[12]

There is a need for PSR services that are gender-sensitive for women with SMI. This chapter details rehabilitation programs of the mentally ill women in India in various contexts, drawing from published reports and personal contributions from service providers. We discuss the meaning of recovery in the global and Indian contexts and why women require special rehabilitation services. Psychopharmacological management of women with schizophrenia can be exceptionally challenging with several biological factors that play significant roles on the prescription practice. This chapter, however, does not include a discussion on the subject.

NEEDS FOR WOMEN WITH SMI—INTEGRAL TO RECOVERY

Needs assessment forms the foundation of rehabilitation programs, individually tailored to promote recovery in keeping with the implication of a multimodal approach to recovery.[13] Several meta-analyses have emphasized on "the need to address the complex health, social, and economic needs of those diagnosed with a chronic and highly disabling illness such as schizophrenia."[14] Assessment of needs of persons with SMI has been reported by several studies in outpatient and inpatient setup.[15-18] Specific to women, the common needs expressed across these studies included welfare benefits, money, company and/or intimate relationships, and more financial incentives for working in day care, along with variety in food and grooming items.[19] Community outreach programs, was a felt need expressed by persons with SMI admitted in a tertiary hospital, especially in areas where limited psychiatric services are available.[20]

Several studies have explored the facilitators and barriers for women with SMI needing PSR.[18] Medication adherence, having a work experience, support from family and coworkers, and financial gain from employment

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were noted to be facilitators. Lack of motivation, medication side effects, lack of proof of identity, stigma from the community, social exclusion, lack of empowerment, and a male-dominated mindset were the key barriers.[21]

Rehabilitation programs need to keep in mind the felt needs of caregivers as well. Several studies have reported on the needs of the families. Family caregivers expressed needs for improvement in hygiene, employment for patients,[15,22] admission for patients to hospitals and help for caregivers for outpatients,[23] and social skills[24] help with changing attitudes for other family members[16,17] vocational training and psychosocial modification.[22] Help in procuring welfare benefits and dealing with psychological distress were the other needs reported by families.[25] A community sample of caregivers also wanted skills training for the patients and jobs.[26] In a study using focused group discussion methodology, caregivers of inpatients with persons with SMI wanted support in managing behavioral problems and social and vocational problems of patients, their own personal health, education about schizophrenia, and managing marital and sexual problems of patients.[18] None of these studies were specific to women.

The context of needs assessments is integral to recovery. It is important that rehabilitation strategies are linked to the needs of patients and their families, in general and specifically for women. In a study conducted on 100 patients and 80 caregivers, 88% of the sample reported that absence of symptoms was an indicator of recovery. Being independent and getting to professional life was perceived as recovery by more than three quarters of the sample in the same study. In this study, women reported that stopping medications was the indicator for recovery.[27] A comprehensive case management would include psychoeducation, social skills training, peer support systems in addition to cognitive remediation, skills training or vocational rehabilitation.[28] Systematic analysis of effective techniques of psychosocial interventions revealed that cognitive remediation, social skills training, psychoeducation, and cognitive therapy (CT) are recommended techniques to promote recovery.[29]

Most reported literature that report general psychosocial interventions are nongender-specific. In a situational analysis of psychosocial interventions programs provided in existing services in two study sites in India and Pakistan, a collaborative and integrated approach when delivering mental health care to patients with psychosis was noted.[30] This approach was noted to be crucial to the long-term and comprehensive management of persons with severe mental health conditions.[31]

PSYCHOSOCIAL INTERVENTIONS DELIVERED TO WOMEN WITH SMI

A large majority of the population of persons with SMI live with their families. However, it has been noted that the ratio of access to treatment between men

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and women is 3:1.[11] This reiterates the need for psychosocial interventions be delivered at the outpatient setting specific to meet the needs of women.

Cognitive Interventions for Psychosocial Interventions

Cognitive deficits play a major role in impairments on functioning in persons with SMI. The association between deficits in cognition and day-to-day functioning in psychosis has good evidence.[32,33] Both genders with schizophrenia performed poorly when compared to normal controls, in a study of cognitive deficits. The same study also showed that among persons with schizophrenia, men had more serious cognitive deficits than women, in immediate and delayed memory, but not in language, visuospatial, and attention indices.[34] A 12-week, group CT intervention that focused on compensatory strategies and habit learning, Twamley and others[35] proposed that cognitive interventions emphasizing habit learning are likely to result in long-term changes in ability to function independently in the community. In India, Gopal et al.[36] have culturally adapted and tested the feasibility of the English version of the compensatory cognitive training (CCT) manual to suit Indian culture. It remains to be seen if this intervention will be useful for activities of daily living (ADL), especially for women with SMI.

Activities of Daily Living

Activities of daily living comprise tasks such as grooming, clothing nutrition, eating, and exercise, and more complex activities for independent living, such as managing finances and medication. Interventions delivered in a community-driven program.[37,38] by lay community workers.[39] or by trained staff[40] appeared to improve patient functioning in the domains of personal care, interpersonal activities, communication, and work. The studies showed that with intervention, improvement in scores of disability and/or functioning were the same or better in women as compared to men. There is little research on gender-specific interventions.

Domestic Chores—A Felt Need

Domestic chores form an integral part of most of the women in Indian setting. Planning for a meal, buying the ingredients, financial management, time management alongside donning multiple hats at home can be quite challenging. In a study with 31 participants (both men and women) who trained for an hour every day for 5 days, the researchers reported that the mental well-being of the participants improved after 2 and 4 weeks.[41] In this study, more females chose to participate. The researchers opined that a nonjudgmental atmosphere in a day care center, peer learning, and appreciation were important factors for the success of the program.

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Further, this program could easily be replicated in resource-scarce settings as it did not require mental health professionals to participate.

At the Schizophrenia Research Foundation (SCARF), a Household Management Efficiency Unit (HOME Unit) has been initiated wherein training for domestic chores would be provided for 4 weeks (5 days per week and 3 hours per day). Vocational skills training for financial sustenance (self-employed or to be employed) and work behavior training (training of soft skills like punctuality, regularity, grooming, working in a team, how to handle success, criticism, stress management) would be dealt with. This program is currently work in progress.

Employment

Work and employment are viewed as important for social inclusion in the community or society.[42,43] Persons with SMI want to work and earn a living. Being employed, in addition to economic gains, also improves self-reliance, self-confidence, being respected by others and facilitates community integration.[44] There are several interventions that have proved to improve employment outcomes for persons with SMI.

Better outcomes of being employed have been reported for with schizophrenia in low- and middle-income country (LMIC). This has been explained on the basis of supportive family, workplace colleagues who are helpful, less stressful, and an informal work opportunities, work timings flexibility, and the lack of high disability pension that acts as a disincentive to work that is given in high-income countries.[45] In addition to the various psychosocial challenges they face, women with SMI have limited access to gainful employment. From a gender perspective, other researchers have stressed on the need for inclusive care centers focusing in skills training for chronic mentally ill women that could facilitate employment opportunities.[10]

In a psychosocial service initiative to improve supportive employment, the Roses Café was initiated as a supportive employment program. It aimed to empower both inpatients and daycare patients in catering skills. Over two-thirds of the persons employed in this activity were women. This program demonstrated that it is possible to empower persons with mental illnesses to live a life of dignity if provided opportunities for a livelihood.[46]

Studies show that opportunities for employment appear to be better in the rural areas for women with mental illnesses as they can be involved in agricultural work, cattle rearing, and related jobs. Jobs are also made available for women through the MNREGA scheme (Mahatma Gandhi National Rural Employment Guarantee Act) which assures 100 days of paid work for one member of the family per year. Flexibility at work and support of family and others at workplace makes it easier for women to sustain in them. Other associated jobs in the agrarian industry like bamboo basket weaving, making

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broomsticks, thatched leaves, cow dung cakes, and vermicompost can be done from the comfort of their homes.[47] Another study in rural Karnataka highlights the systemic and personal barriers of rural women in finding jobs and sustaining in them which includes stigma and lack of access to benefits and means.[21] Self-help groups (SHGs) are another resource for many women in rural areas. Many treated women with SMI are seen to be part of regular SHGs. Women with severe mental illnesses are incorporated in "special" disability (other than mental illness) SHG.[48]

On background of increasing evidence that being employed reduces chances of relapse and also reduce stigma discrimination significantly, there is a great need to move beyond the routine thinking around employment and financial inclusion of people with SMIs. The THRIVE (Therapeutic interventions, Habit and routine, Relational-social, Individual differences, Values and beliefs, and Emotional factors) model, developed by Parivarthan an nongovernmental organization (NGO) in Maharashtra, is based on an adaptation of the social ecological model. While this is not gender-specific, it offers a good opportunity to women with SMI.

Peer Support

Recent literature has focused on the role of peer support as an established intervention for a person who has lived with mental illness. In India, the first effort at involving persons with lived experience was the peer support program as part of the quality rights program in Gujarat.[49] A survey of patients with psychoses, their families and mental health clinicians to understand the feasibility and acceptance of peer support volunteers led interventions, in a tertiary care setting, showed that majority of the participants accepted peer support interventions. Women caregivers in this study reinforced the need for peer support for their relatives especially for day-to-day living.[50]

Rehabilitation of Women in an Inpatient Setting

Reviews about inadequacies in mental health care for women have been voiced by a number of researchers[10] care providers[4] users and activists.[42] In UK, a strategy document that provided guidelines to organizations on planning and delivery of mental health services for women[51,52] included the need for access to services exclusively for women–group and social activities; single-sex lounges, sleeping, toilet and bathing facilities. Service evaluation reported that most projects provided dedicated spaces for women, female service users had a female case manager. However, the uptake of women-only groups and activities was limited. This report recommended a focus on working together with female service users to identify and set up programs that appeal to women service users was critical to worthwhile engagement.[51]

In a study conducted at a private medical college hospital, inpatients with schizophrenia were provided interventions for 4 weeks on a self-care

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module. There was improvement on post scores, with both men and women showing improvement.[53] It remains to be seen whether group interventions for cognitive deficits as recommended by Twamley et al.[35] and Gopal et al.[36] is feasible in a residential care setting.

Admissions to residential care can happen due to various reasons other than crisis management. A third of persons with chronic conditions require long-term care.[46] Admissions provide opportunities to develop emotional, personal, cognitive, social, intellectual, and occupational skills needed to live in the community with minimal professional support toward an feasible recovery.[54]

The few published studies on PSR in a residential setting from India report that as assessed at the time of the first intake of the inpatient referrals, vocational rehabilitation is the most common need for planning psychosocial interventions.[55] A study from another half-way home reports that interventions that include individuals and families are effective.[56] There are no details of the methods of interventions in these reports. When a woman is admitted for residential care, families expect the woman to be able to handle household responsibilities independently when they return home. These include doing the laundry, cooking, and cleaning chores. It is important that these activities get incorporated into the routine of the inpatient facility.[56]

Rehabilitation at a Residential Facility Run by an NGO

Experience at Bavishya Bhavan, the residential facility for women, run by the SCARF, India, indicates that improvement in personal care and hygiene is very often a felt need. Women with difficulty in attending to brushing and bathing may have to be trained to do so and supervised regularly to ensure that the task is done. Menstrual hygiene, including education about use of sanitary napkins, safe disposal, keeping clean, and proper washing of soiled clothes are areas that need address. Women are encouraged to keep their rooms clean or participate in cleaning a small area of the facility under supervision. They are engaged in simple tasks like peeling skins of vegetables, separating greens from stems, or cutting vegetables under supervision. Training in making meal plans, in execution of cooking recipes by breaking them into smaller steps, allowing them to cook small portions of simple recipes under supervision or engaging them in fireless cooking, helps to make them more functional when they return to their homes. To meet the need for vocational rehabilitation,[48] a vocational training center within the inpatient premises will help in the rehabilitation process. Activities like sewing, embroidery, tailoring, and craft activities, can be made available besides opportunities for leisure activities like drawing, coloring, and music. Following a structured schedule, for a significant amount of time in a residential facility till it becomes an easy routine for the person, helps them to step back into their roles in the outside

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world with ease. Unpublished qualitative feedback from the staff (nurses, psychiatric social workers, and occupational therapists) indicates that these interventions can be systematically delivered in a residential care setup.

Residential centers are places where peer support comes to play in a significant way in our experience. Women develop close friendships with other residents which can be exploited to benefit all, but may need some supervision and guidance. The instinctive caregiving tendencies of women can be put to good use in helping those in distress or need and they can become an ally in taking care of difficult, dysfunctional patients.

With reduced life expectancy for persons with SMI attributed to physical health conditions,[57] researchers have recommended to role of physical activity in different forms.[58-60] Although gender-specific literature is limited, it is important to include adequate physical activities like yoga, dance, and walking to improve their mobility, control weight gain, and feel better. At SCARF, emphasis is laid on graded physical activity that includes yoga and walking. Personal and staff narratives report the value of this practice. This however, needs to be examined in a systematic manner.

Where families are available, it is important to engage in dialogs with the patient and caregivers and make a clear post-discharge plan. It is important to keep the family informed about progress happening in their ward while in the facility and encourage them to visit the patient regularly. Getting into their roles at home can become difficult if the period of stay in a structured environment is prolonged.

All efforts in rehabilitation in a residential facility is incomplete without ensuring continuity of care in the community. This is important to sustain the improvement gained in the residential facility.

Women who stay for longer periods in a rehabilitation facility with no imminent exit plans have a different set of needs besides those mentioned above. They need to be engaged adequately to maintain or improve their functionality to prevent deterioration. Providing avenues to express themselves through activities and responsibilities improves self-esteem and mental wellness in these women. Celebrating important festivals, national days, birthdays, and specific days on the mental health calendar and allowing them to entertain themselves by showcasing their skills, preparing special food, and dressing up well help in improving the mood and general sense of well-being among residents. Incentivizing some of the tasks in cash or kind infuses lots of enthusiasm and pride in what they do.

While television and newspapers do help them to stay in touch with the outside world, it is important that they are allowed to go out as often as possible in groups or alone, accompanied by someone if needed, for specific needs or for recreation. This allows them to have a sense of freedom and belonging to the world outside.

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ROLE OF NURSING CARE IN AN INPATIENT SETTING

Nurses play a major role in the inpatient setting. In any psychiatric setting, it is the nurse who spends maximum time interacting with the patients, for a better understanding of their background and problems. However, there is limited literature on nurses and nursing care in a psychiatric in patient facility from India. In a study of nurses who completed a self-report questionnaire to assess knowledge and perceptions toward mental illness, it was observed that the respondents noted adequate knowledge on mental illness among nurses. However, the responses also reflected negative attitudes, implying stigma toward mental illness.[61]

GROUP INTERVENTIONS

Psychosocial groups have been recommended as relevant intervention in communities. In a scoping review of group interventions in south east Asia, this intervention was recommended as effective to promote and increase awareness of mental health in communities[9] and in mental health centers.[18] At SCARF group activities including games, reading, and listening, conversations are used as methods to improve communication skills and social interactions.

Does it Matter How and Where It is Offered?

One study highlighted that brief outpatient-based across-the-table psychosocial interventions were as effective as structured facility-based interventions, highlighting that setting did not matter as long as the techniques were feasible and pragmatic. A retrospective chart analysis of the PSR techniques showed that including "regular telephonic interventions to face-to face PSR sessions" were as advantageous as "only face-to-face interventions", for those patients who could not attend for interventions in person. Thus, technology can be used to deliver psychosocial interventions.[62]

IMPROVING ACCESS TO WELFARE BENEFITS AS PART OF PSYCHOSOCIAL INTERVENTIONS

Community-based interventions play an important role to reintegrate persons with lived experiences of mental illnesses into the society. It has been demonstrated repeatedly that it is cost-effective to include mental healthcare in community-based rehabilitation (CBR) programs. It allows for equal opportunities and full participation for persons with all disabilities to access their resources.[63] Analysis of data from a SCARF led TElepsychiatry program in Pudukkottai (STEP) in the rural communities of Tamil Nadu, which showed that a range of PSR activities were provided to persons with SMI and their family members. These included enabling securing disability

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and welfare benefits, help with getting jobs, obtaining loans from banks to start small businesses, help with mental health crisis situations including admissions. This data demonstrated that it was feasible to integrate psychosocial interventions in community-based programs for persons with SMI.[48] Both reports were not gender-specific.

PREGNANCY, LACTATION, AND PARENTING IN WOMEN WITH SEVERE MENTAL DISORDERS

Women with SMI get married and have children.[64] However, negative sequelae of pregnancy and the subsequent postpartum period have also been noted.[65] Women with schizophrenia and related disorders were noted to be younger, had more relapses, had less family support, were more likely to be single, and had a higher prevalence of smoking and substance misuse during pregnancy compared with women with affective illnesses. This suggests that women with severe mental disorders need more support to optimize both psychiatric and obstetric adverse outcomes. Psychosocial interventions that meet the special needs of mothers with schizophrenia and their children are limited.[66] A higher rate of unplanned and unwanted pregnancies has been noted in women with schizophrenia and related disorders.[41] There indicates a dire need for psychosocial interventions to support these women to make decisions about birth control as well as care during pregnancy. Medication during pregnancy and the postpartum periods are of special concern and need to be addressed.[67] Mother and baby units (MBUs) in inpatient mental health service for women experiencing acute severe postpartum psychiatric difficulties to be admitted with their babies has been a significant development. The first MBU in India was started in 2009 at NIMHANS (National Institute of Mental Health and Neurosciences), Bengaluru, as a five-bedded unit.[65] Bonding interventions and maintenance or restitution of lactation were an important part of care in an MBU. Chandra et al.[68] emphasized on the need for assessments and interventions to provide care for the mother and infant dyad that included both clinical management, infant health, and handling of mother–infant interactions. This study demonstrated that clinical outcomes for the mother with SMI were significantly good as was the relationship between the mother and the infant dyad. More such units are now being established across in the country in both private and government institutions.

Parenting is a rewarding experience for women with severe mental illness, giving hope and satisfaction. Studies have shown that parents are more hopeful than nonparents and hope plays a big role in the individual's recovery process.[69] However parenting can pose a huge challenge to the woman placing high demands on her, affecting parenting methods and impacting the children too. They end up as single parents with provider role

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added on the parenting role. They are afraid to express their concerns about their challenges as they run a risk of losing the custody of the children. Stigma and societal attitudes also affect the parents and the children.[70]

OTHER INTERVENTIONS

The challenges like difficulty in access to services, shortage of mental health professionals, poor mental health awareness, religious beliefs, stigma and poverty contribute to significant mental morbidity, and stress on the need for innovations in care services.[48] While they are not always women-specific, some of them have been useful in the rehabilitation of women with SMI. We have highlighted some of them in this section.

Women Self-help Groups

Providing interventions like psychoeducation, peer support, and referral, with women from SHGs has a positive impact on their mental health. A study showed that women felt relaxed and were comfortable in sharing their problems with peers, experienced reduced emotional distress and physical symptoms, and slept better.[48]

Collaborative Community-based Interventions

It has been shown that CBR delivered using community health workers alongside mental health specialists is feasible and effective in improving clinical and social outcomes of persons with schizophrenia.[38] The COPSI (Care for People with Schizophrenia in India) study provides rigorous evidence about effectiveness of use of supervised community health workers, most of them being women in service delivery in resource-depleted places. This research demonstrated the feasibility and acceptability of community-based intervention which showed a positive impact on reducing disability for a majority of people with psychotic disorders in low-resource settings.[39] However, women-centric evidence needs to be generated.

Family-centric Rehabilitation for Women

The Indian family system values interdependence and mutual concern as key elements and play a vital role in recovery of persons with SMI.[10] Caregiver burden and its impact on their quality of life expressed as physical, emotional, and financial difficulties has been recognized across several studies.[71,72] To address this, a model that included whole families as target for intervention was conceptualized. This study[71] showed that the process facilitates families to reach optimal level of functioning. There is, however, limited research addressing women specifically.

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Namma Area (Our Space)

As an experiment at SCARF, a hangout space for persons with lived experiences of mental illnesses was conceived to improve socialization, independence, and reduce apathy and avolition. This facility, underway at SCARF premises twice a week for 4 hours each day, with an average 8–10 men and women is currently being evaluated. The place is owned by the members who use it and activities are planned by them which includes games, music, watching movies, group discussions on themes chosen by them. This also includes group outings accompanied by staff from SCARF. Anecdotal reports from service users and families show that this service has benefitted the mental wellness of the persons using it and has improved communication and social interactions and interest to work in a group.

Homelessness

Circumstances leading to homelessness among women with chronic mental illness is not satisfactorily represented in research and at policy levels. Homeless women are "invisible", and when women with mental illness have wandered for a period, the family seldom take them back home.[73] Homeless mentally ill women are at high risk of exploitation, sexual and physical abuse, unwanted pregnancies or infectious diseases like human immunodeficiency virus (HIV) besides loss of dignity.[74] The need for better shelter homes for homeless women with mental illness has been stressed upon by several studies.[74] A study done on women in a shelter home showed that many women had insight about their illness, its impact on their functioning and need for medication. But reintegration with families remains a challenge as families lack awareness, experience stigma and fear the possibility of relapse which can create problems for the whole family.[73] This underlines the importance of regular psychoeducation for the families and sensitizing local communities about mental illnesses to facilitate reintegration.

Several state-run and NGO-operated institutions are actively involved in rehabilitating homeless women and reintegrating them with families and in the community.[74] These include state-run institutions such as the Hospital for Mental Health (Ahmedabad) and the *Institute for Health and Behavioural Sciences* (Delhi) and nongovernmental agencies, such as *Ashadeep* (Guwahati), *Iswar Sankalp* (Kolkata), *Koshish* (Mumbai), *Banyan* (Chennai), and *Parivartan* (Maharashtra) are actively involved in rehabilitating homeless women and reintegrating them with families and in the community.[74] It would be worthwhile to collate these different experiences to help create a knowledge base to develop socially relevant policy and robust evidence-based practices.

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Women's Mental Health

Women's Mental Health has till recently not received the attention it deserves, partly due to lack of sex and gender aggregated data in research studies and also due to an undue focus only on reproductive health issues. The last decade has seen an increase in studies on several aspects of the mental health of women including sociocultural determinants and life course issues. There has also been increased emphasis on sex specific issues in pharmacological and other forms of treatment as well in developing gender sensitive services that address the needs of women with mental health problems including those linked to trauma.

Jostling for shelf space with many other books on mental health, we wanted this book to appeal to professionals in India and South Asia while conceptualizing the cultural aspects of mental health in a woman, addressing violence, using a life course approach or making a treatment plan or indeed in planning gender sensitive mental health. The book is divided into four sections, each ably handled by a different editor.

Section 1 deals with the clinical aspects of psychiatric disorders, Section 2 discusses the area of reproductive psychiatry, Section 3 dwells on important aspects of vulnerability, autonomy and power imbalances that affect women's mental health including gender-based violence and Section 4 looks at more contemporary topics related to the practice of women's mental health including assessment, formulation and services. The themes in the book offer guidance on how to view a woman's mental health from a gendered and cultural lens as well as an approach to developing gender sensitive mental health services.

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Printed in India

Available at all medical bookstores
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JAYPEE BROTHERS
Medical Publishers (P) Ltd.
EMCA House, 23/23-B, Ansari Road,
Daryaganj, New Delhi - 110 002, INDIA
www.jaypeebrothers.com

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ISBN 978-93-5696-722-9
9 789356 967229