



Review Article

Women's Mental Health and Mental retardation

Sharadha Ramesh*

Professor & Director, Symbiosis College of Nursing, Symbiosis International University, Pune, Maharashtra, India

***Address for Correspondence:** Sharadha Ramesh, B.Sc (N), M.Sc (N), Ph.D, Professor & Director, Symbiosis College of Nursing, Symbiosis International University, Pune, Maharashtra, India, Email: sharadharamesh@rediffmail.com; sharadharamesh@gmail.com

Submitted: 22 June 2018

Approved: 03 September 2018

Published: 04 September 2018

Copyright: © 2018 Ramesh S. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Introduction

Mental illness is associated with a significant burden of morbidity and disability. Lifetime prevalence rates for any kind of psychological disorder are higher than previously thought, are increasing in recent cohorts and affect nearly half of the population. Overall rates of psychiatric disorder are almost identical for men and women but striking gender differences are found in the patterns of mental illness. Gender is a critical determinant of mental health and mental illness. Gender differences occur particularly in the rates of common mental disorders - depression, anxiety and somatic complaints. These disorders, in which women predominate, affect approximately 1 in 3 people in the community and constitute a serious public health problem [1].

Unipolar depression, predicted to be the second leading cause of global disability burden by 2020, is twice as common in women. Depression is not only the most common women's mental health problem but may be more persistent in women than men. In developed countries, approximately 1 in 5 men and 1 in 12 women develop alcohol dependence during their lives [2]. The disability associated with mental illness falls most heavily on those who experience three or more comorbid disorders; again, women predominate.

Gender specific risk factors

Mental health problems affect women and men equally, but some are more common among women. A woman in worldwide, face gender-based discrimination at every stage of their lives, their psychological well-being becomes a cause for great concern. Abuse is often a factor in women's mental health problems.

Depression, anxiety, somatic symptoms and high rates of comorbidity are significantly related to interconnected and co-occurrent risk factors such as gender based roles, stressors and negative life experiences and events. Gender specific risk factors for common mental disorders that disproportionately affect women which include gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others.

The high prevalence of sexual violence to which women are exposed and the correspondingly high rate of Post-Traumatic Stress Disorder (PTSD) following such violence render women the largest single group of people affected by this disorder [3]. Economic and social policies that cause sudden, disruptive and severe changes to income, employment and social capital that cannot be controlled or avoided, significantly increase gender inequality and the rate of common mental disorders.

Gender bias

Gender bias has been observed in the diagnosis and treatment of psychological disorders. Physicians are more likely to diagnose depression in women than in men, even when patients have similar scores on standardized measures of depression or present with identical symptoms. Female gender is a significant predictor of being prescribed mood altering psychotropic drugs. Women are more likely to seek help from and disclose mental health problems to their primary health care physician. Gender stereotypes regarding proneness to emotional problems in women and alcohol problems in men appear to reinforce social stigma and constrain help seeking behavior along the stereotypical lines. They are a barrier to the accurate identification and treatment of psychological disorder. Violence related mental health problems are also poorly identified [4]. Women are reluctant to disclose a history of violent victimization unless physicians ask about it directly. The complexity of violence related health outcomes increases when victimization is undetected and results in high and costly rates of utilization of the health and mental health care system.

Differences in the epidemiology of mental disorders in men and women are well-established and are often conceptualized as being due to sex (ie, biological) differences; the increased risk of psychosis in the postpartum period is a classic example. Sex differences in both response and adverse reactions to psychotropic medication have been identified, as have sex differences in gastric pH, the expression of metabolic enzymes and drug transporters, and drug clearance (eg, of zolpidem). Social determinants, such as poverty and gendered risk factors, intersect with other structural inequalities in their effect on mental health—eg, as described in this issue, women with severe mental illness are at particularly high risk of domestic and sexual violence [5].

Women of childbearing age are often excluded from biomarker studies and drug trials because of teratogenicity concerns. Most mental health research is therefore still gender-neutral, or overtly sex-biased or gender-biased and the underlying reasons are comparatively under-researched.

Women's mental health: The Facts

- Depressive disorders account for close to 41.9% of the disability from neuropsychiatric disorders among women compared to 29.3% among men.
- Leading mental health problems of the older adults are depression, organic brain syndromes and dementias and a majority is women.
- An estimated 80% of 50 million people affected by violent conflicts, civil wars, disasters, and displacement are women and children. Lifetime prevalence rate of violence against women ranges from 16% to 50%. At least one in five women suffers rape or attempted rape in their lifetime.

Suicide attempts: Men die from suicide at four times the rate that women do, but women attempt suicide two or three times more often than men.

Eating disorders: Women account for at least 85 percent of all anorexia and bulimia cases and 65 percent of binge-eating disorder cases [6].

Depression, anxiety, psychological distress, sexual violence, domestic violence and escalating rates of substance use: It affects women to a greater extent than men across different countries and different settings. Pressures created by their multiple roles, gender discrimination and associated factors of poverty, hunger, malnutrition, overwork, domestic violence and sexual abuse; combine to account for women's poor mental health. There is a positive relationship between the frequency and severity of such social factors and the frequency and severity of mental health problems in women.



Severe life events that cause a sense of loss, inferiority, humiliation or entrapment can predict depression. Up to 20% of those attending primary health care in developing countries suffer from anxiety and/or depressive disorders. According to a recent survey by the Substance Abuse and Mental Health Services Administration, 29 million American women, or about 23 percent of the female population, have experienced a diagnosable mental health-related disorder in a year and those are just the known instances [7]. Experts say that millions of other cases may go unreported and untreated.

Mental Health: Women's Health Issues: Some mental health conditions occur more often in women and can play a significant role in the state of a woman's overall health. Mental health conditions more common in women include:

Depression: Women are twice as likely as men (12 % of women compared to 6% of men) to get depression [8].

Anxiety and specific phobias: Although men and women are affected equally by such mental health conditions as obsessive-compulsive disorder and social phobias, women are twice as likely as men to have panic disorder, generalized anxiety, and specific phobias.

Post-traumatic stress syndrome (PTSD): Women are twice as likely to develop PTSD following a traumatic event [9].

Suicide attempts: Men die from suicide at four times the rate that women do, but women attempt suicide two or three times more often than men.

Eating disorders: Women account for at least 85 percent of all anorexia and bulimia cases and 65 percent of binge-eating disorder cases.

Mental Health: Why the Gender Differences? It is because of Biological influences - caused by medical illness including chromosomal abnormalities, poor sleep, substance abuse, prenatal assault, poor nutrition and exposure to toxins, chemical imbalance or dysfunction in the neural pathways

Socio-cultural influences - caused by low income, low status jobs - often part-time, physical and sexual abuse of girls and women, widowhood or divorce and playing multiple roles - they may be mothers, partners and careers as well as doing paid work and running a household. This combination can increase their risk of experiencing mental distress.

Behavioral influences - caused by compulsive buying disorder, social media addiction, unhealthy or inconsistent discipline style, poor attitude toward education or schooling etc.

Focus in Women's Mental Health:

Build evidence on the prevalence and causes of mental health problems in women as well as on the mediating and protective factors.

Promote the formulation and implementation of health policies that address women's needs and concerns from childhood to old age.

Enhance the competence of primary health care providers to recognize and treat mental health consequences of domestic violence, sexual abuse, and acute and chronic stress in women.

Mental retardation – role of a nurse

Mental retardation is a generalized, triarchic disorder, characterized by sub average cognitive functioning and deficits in two or more adaptive behaviors with onset before the age of 18. Once focused almost entirely on cognition, the definition now includes both a component relating to mental functioning and one relating to the individual's functional skills in their environment.



Mental Retardation is a part of a broad category of developmental disability; it is defined by the American Association of Mental Deficiency as significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period (18 years of age) [10]. Adaptive behaviors include communication, self-care, work, leisure, health, and safety.

Causes of mental retardation are genetic, biochemical, viral, and developmental. Other factors include

- Prenatal Infection and intoxication
- Trauma or physical agent (e.g. lack of oxygen)
- Metabolic Disturbance
- Inadequate Prenatal Nutrition
- Gross postnatal brain disease (e.g. Neurofibromatosis or tuberous sclerosis)
- Chromosomal abnormalities
- Prematurity
- Low birth weight
- Autism
- Environmental deprivation

Associated Factors Include:

- Maternal Lifestyle (e.g. Poor nutrition, smoking, and substance abuse)
- Chromosomal disorders (most related to Down Syndrome)
- Specific Disorders such as fetal alcohol syndrome
- Cerebral Palsy, microencephaly or infantile spasms

Treatment

By most definitions mental retardation is more accurately considered a disability rather than a disease. Mental Retardation can be distinguished in many ways from mental illness, such as schizophrenia or depression. Currently, there is no “cure” for an established disability, though with appropriate support and teaching, most individuals can learn to do many things [11]. Although there is no specific medication for mental retardation, many people with developmental disabilities have further medical complications and may take several medications. Beyond that there are specific programs that people with developmental disabilities can take part in wherein they learn basic life skills. These “goals” may take a much longer amount of time for them to accomplish, but the ultimate goal is independence [8]. This may be anything from independence in tooth brushing to an independent residence. People with developmental disabilities learn throughout their lives and can obtain many new skills even late in life with the help of their families, caregivers, clinicians and the people who coordinate the efforts of all of these people.

Nursing Management:

1. Assess all children for signs of developmental delays.
2. Administer prescribed medications for associated problems such as anticonvulsants for seizure disorders, and methylphenidate (Ritalin) for Attention Deficit Hyperactivity Disorder.



3. Support the family at the time of initial diagnosis by actively listening to their feelings and concerns and assessing their composite strengths.
4. Facilitate the child's self-care abilities by encouraging the parents to enroll the child in an early stimulation program, establishing a self-feeding program, initiating independent toileting, and establishing an independent grooming program (all developmentally appropriate).
5. Promote optimal development by encouraging self-care goals and emphasize the universal needs of children, such as play, social interaction and parental limit setting.
6. Promote anticipatory guidance and problem solving by encouraging discussions regarding physical maturation and sexual behaviors.
7. Assist the family in planning for the child's future needs (e.g. Alternative to home care, especially as the parents near old age); refer them to community agencies.
8. Provide child and family teaching.
9. Identify normal developmental milestones and appropriate stimulating activities including play and socialization.
10. Discuss the need for patience with the child's slow attainment of developmental milestones.
11. Inform parents about stimulation, safety and motivation.
12. Supply information regarding normal speech development and how to accentuate nonverbal cues, such as facial expression and body language, to help cue speech development.
13. Explain the need for discipline that is simple, consistent and appropriate to the child.
14. Review an adolescent's need for simple, practical sexual information that includes anatomy, physical development and conception.
15. Demonstrate ways to foster learning other than verbal explanation because the child is better able to deal with concrete objects than abstract concepts.
16. Point out the importance of positive self-esteem, built by accomplishing small successes in motivating the child to accomplish other tasks.
17. Encourage the prevention of mental retardation.
18. Encourage early and regular prenatal care.
19. Provide support for high risk infants.
20. Administer immunizations, especially rubella immunization.
21. Encourage genetic counseling when needed.
22. Teach injury prevention – both intentional and unintentional.
23. The women can be encouraged to undergo early identification and intervention for the mental health problems. Help them to learn ways to encourage, experience and model a positive climate in the workplace and a balanced lifestyle; including a staff environment which supports healthy diet, exercise, family time and allows time to give positive feedback and celebration of successes.
24. Intentional injuries are caused by domestic violence, physical and sexual assault and abuse, suicide, and bullying, to name a few. It can be prevented implementing

policies, laws, and safeguards at schools, homes, and the community. Training women in risk recognition, risk prevention, and risk intervention may help to curb intentional violence in schools, homes, and communities.

25. Timely execution of screening program (e.g., newborn metabolic screening) is essential to identify preexisting mental illness as a risk factor for unintentional injury.

Conclusion

Mental health in women and mental retardation among children in the community setting requires a need based care and role of nurse is in high demand in both these areas of care. Research, psychiatric training, and practice should consider sex and gender aspects much more strongly. It is a high time to implement an urgent remedial measure such as understanding the underlying causes of psychological distress among women, adopting a gender-sensitive approach, working towards women's empowerment and formulating women-friendly health policies could work wonders for the mental health of women.

References

1. Pigott TA. Women's Mental Health – A Comprehensive Textbook. In: Kornstein SG, Clayton AH, editors. The Guilford Press: New York; 2002. [Ref.: https://goo.gl/PJJQws](https://goo.gl/PJJQws)
2. Geneva: World Health Organization; 2000. Women's Mental Health: An Evidence Based Review.
3. Thara R, Patel V. World Health Organization. Women's mental health: A public health concern. In: Regional Health Forum-WHO South-East Asia Region. 2001; 5.
4. Nayak MB, Patel V, Bond JC, Greenfield TK. Partner alcohol use, violence and women's mental health: Population-based survey in India. *Br J Psychiatry*. 2010; 196: 192-199. [Ref.: https://goo.gl/m8rSRe](https://goo.gl/m8rSRe)
5. Howard LM, Ehrlich AM, Gamlen F, Oram S. Gender-neutral mental health research is sex and gender biased. *The Lancet Psychiatry*. 2017; 4: 9-11. [Ref.: https://goo.gl/h7bBzF](https://goo.gl/h7bBzF)
6. Shidhaye R, Patel V. Association of socio-economic, gender and health factors with common mental disorders in women: A population-based study of 5703 married rural women in India. *Int J Epidemiol*. 2010; 39: 1510-1521. [Ref.: https://goo.gl/AJrwxH](https://goo.gl/AJrwxH)
7. Geneva: World Health Organization; World Health Organization. Gender and women's mental health. Gender disparities and mental health: The Facts. 2001;
8. Piccinelli M, Homen F. Geneva: World Health Organization. Gender Differences in the Epidemiology of Affective Disorders and Schizophrenia. 1997; [Ref.: https://goo.gl/eVxAPt](https://goo.gl/eVxAPt)
9. Kumar S, Jeyaseelan L, Suresh S, Ahuja RC. Domestic violence and its mental health correlates in Indian women. *Br J Psychiatry*. 2005; 187: 62-67. [Ref.: https://goo.gl/R5BBGs](https://goo.gl/R5BBGs)
10. American Association on Mental Retardation. Mental retardation: Definition, classification, and systems of support (9th ed.). Washington, DC: American Association on Mental Retardation. 1992; [Ref.: https://goo.gl/BT2NVh](https://goo.gl/BT2NVh)
11. Campbell M, Malone RP. Mental retardation and psychiatric disorders. *Hospital and Community Psychiatry*. 1991; 42: 374-379. [Ref.: https://goo.gl/vS26bS](https://goo.gl/vS26bS)