Women And Mental Health

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ABSTRACT

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

Key Words: mental illness, women, family functioning.

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INTRODUCTION

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

WOMEN AND PSYCHIATRIC DISORDERS

Depression

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

Bipolar Disorder

The presentation of bipolar disorder in women differs from that in men in clinically significant ways. Bipolar I disorder occurs equally in both sexes, while Bipolar II disorder occurs more frequently in women than in men (Dunner, 1998).The course of bipolar disorder in women differs from that in men in several ways. First, women generally have a later age of onset, with onset during the fifth decade of life being more common (Leibenluft, 1996). Second, "rapid cycling" is about three times more common in women than men. In studies of rapid cycling, the percentage of

female patients has ranged from 58% to 92%, with a mean of approximately 71% (Leibenluft, 1997). Finally, in women, depressive episodes occur more commonly in the fall and winter than in the spring and summer (Faedda et al., 1993).

Comorbidity is more common in women than in men and adversely affects recovery from mania more often in women (Blehar et al., 1998; Strakowski et al., 1992). Medical disorders that are frequently comorbid with bipolar disorder include migraine headaches and thyroid disease, both of which are also more common in women with bipolar disorder than men (Blehar et al., 1998). Hypothyroidism may contribute to the elevated rates of rapid cycling in women. (Bauer et al., 1990; Tunbridge et al., 1997).

Schizophrenia

Symptoms of schizophrenia during acute psychotic episodes, whether at first break (Szymanski et al., 1995) or at relapse (Haas et al., 1990; Perry et al., 1995), do not differ between women and men in either types or severity, but several studies have reported gender differences in predominant symptom clusters outside of acute stages. Specific positive symptoms (such as paranoia, persecutory delusions, and auditory hallucination), and some affective symptoms (e.g., dysphoria), are more common in women. Negative symptoms, including affective flattening and social withdrawal, tend to be more sever in men (Szymanski et al., 1995; Shtasel et al., 1992).

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

Neurocognitive functioning- Findings from studies of gender differences in neurocognitive functioning, however, are inconsistent. Although some studies have found men to be more impaired than women in sustained attention, verbal memory, language, executive functions, and intelligence (Goldstein et al., 1994; 1998), others have failed to find gender differences or found the relationship to be complicated. Many argue that these inconsistent findings result from different sampling strategies

and inadequate sample size (Walker & Lewine, 1993; Goldstein et al., 1998).

Anxiety Disorders

Estimates based on data from the Epidemiologic Catchment Area (ECA) study and the NCS suggest that lifetime prevalence rates in females, for panic disorder (3.4% vs. 0.9%), agoraphobia (9.0% vs. 3.0%), specific phobia (13.9% vs. 7.2%), generalized anxiety disorder (GAD) (7.7% vs. 2.9%), and posttraumatic stress disorder (11.3% vs. 6.0%), are two to three times greater than those demonstrated in males (Kessler et al., 1994; Regier et al., 1988; Robins et al., 1984; Boyd et al., 1990; Breslau et al., 1997; Joyce et al., 1989). Females are more frequently afflicted with anxiety disorders at every age, although the overall incidence decreases with advancing age. There is a narrowing in the gender difference for anxiety disorder prevalence rates after the age of 65 years (Krasucki et al., 1998). Increased anxiety sensitivity has been reported to occur in the luteal, in comparison to the follicular, phase of the menstrual cycle (Fishman et al., 1994). Elevated rates of anxiety symptoms are also reported during perimenopause; the presence of very high levels of follicle-stimulating hormone during this period may be helpful in distinguishing women who have depression or anxiety disorders from those who are merely perimenopausal (Huerta et al., 1995).

Pregnancy and the postpartum period have also been linked to substantial changes in anxiety symptoms, including the onset of an anxiety disorder, as well as significant changes in the severity of preexisting anxiety disorders (Fava et al., 1990).

Generalized anxiety disorder (GAD)

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

is present within an individual. Little is known about the impact of the female reproductive cycle on the development or course of GAD.

Panic disorder

Data from epidemiological surveys indicate that females are two to three times more likely than males to develop panic disorder (Kessler et al., 1994; Weissman et al., 1997). Most reports suggest that panic disorder typically emerges in the mid-twenties (Eaton et al., 1991; Kessler et al., 1994), although some reports have suggested additional peaks of onset during adolescence (Weissman et al., 1997; Reed & Wittchen, 1998) and between 30 and 40 years of age (Dick et al., 1994a). Females with panic disorder report more individual panic-related symptoms and a greater level of phobic avoidance than males (Dick et al., 1994a; Turgeon et al., 1998). Females with panic disorder are also more likely to report situations such as leaving home or using public transportation as precipitants for panic attacks (Starcevic et al., 1998), indicating greater levels of dependence and functional impairment in comparison to males. In general, females with panic disorder have a greater risk for comorbid psychiatric disorders than males with panic disorder do (Yonkers & Ellison, 1996), and agoraphobia occurs more frequently in females with panic disorder (Starcevic et al., 1998). Panic disorder with agoraphobia is more likely to be complicated by social phobia or PTSD in females (Turgeon et al., 1998). Comorbid psychiatric disorders such as depression, GAD, specific phobia, and somatization disorder also occur more frequently in females with panic disorder (Yonkers & Ellison, 1996; Marshall, 1996; Andrade et al., 1996).

Specific phobia

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

Social anxiety disorder

Lifetime prevalence estimates suggest that females have a slightly higher lifetime prevalence risk for social anxiety (1.5 times; 15.5% vs 11.15%) than males (Kessler et al., 1994; Dick et al., 1994b). However, men may seek treatment significantly more often than women when social anxiety disorder is present

(Weinstock, 1999). However, women reported significantly greater fear in association with a wide range of activities, including talking to authority figures, acting/ performing/ speaking/working in front of others or while being observed, expressing disagreement or disapproval to people they did not know very well, or giving a party. Other reports have suggested that agoraphobia may co-occur at a greater rate in females than in males with social anxiety disorder (Lecrubier & Weiller, 1997).

Obsessive Compulsive Disorder (OCD)

Males typically have an earlier onset of OCD than females. Dopamine dysregulation may be more prominent in males with OCD, whereas gonadal steroid hormones and their complex interactions with serotonin may be more critical to the development of OCD in females. The dramatic shift that occurs in gender prevalence rates for OCD after the onset of puberty provides support for the importance of female reproductive hormones. Females begin to develop OCD at a much greater rate than males after menarche; the increase is so robust that the overall prevalence rate in OCD is greater for females (1:5:1) than males (Weissman et al., 1994). Gender differences have also been identified in the phenomenology and clinical course of OCD. Aggressive obsessions and cleaning compulsions may occur more frequently in females with OCD (Lensi et al., 1996; Castle et al., 1995). Adolescent females endorsed a greater amount of compulsive rituals, whereas obsessions were more common in adolescent males with OCD. Women with OCD may also have a more episodic clinical course and less severe symptoms (Hantouche & Lancrenon, 1996; Thomsen & Mikkelsen, 1995). Females with OCD may also have a greater risk of certain comorbid conditions like panic disorder, anorexia nervosa, and bulimia nervosa. (Yaryura-Tobias et al., 1995; Kendler et al., 1995; Lensi et al., 1996; Castle et al., 1995). The premenstrual period (late luteal phase) may be associated with an exacerbation in symptoms in females with OCD (Yaryura-Tobias et al., 1995; Williams & Koran 1997). Changes in female reproductive hormone concentrations can substantially influence the severity and course of OCD. Pregnancy and the postpartum period may represent a time of increased vulnerability for the initial emergence of OCD (13-35%) or for significant worsening in women with preexisting OCD (Williams & Koran, 1997; Neziroglu et al., 1994; Altshuler et al., 1998).

Alcohol and Other Substance Abuse

A number of social factors differentiating women from men with regard to substance use have been identified (Brady & Randall, 1999). Women experience more social disapproval of substance use, and substance use is more stigmatized in women than in men (Blume, 1986). Women with alcoholism are more likely than men to have alcoholic role models in their nuclear families

and to have spouses who are also alcoholic (Lex, 1991).Substance use for men is more likely to affect jobs or career, whereas disruptions for women are more likely to occur in family life. More women with substance use problems are separated or divorced compared with men (Lex, 1991).Women are more likely to attribute their drinking to a traumatic event or a stressor (Lex, 1991), and women who abuse alcohol and drugs are more likely to have been sexually or physically abused than other women (Gearon et al., 2003). In addition, women with alcoholism are more likely than men to have another mental disorder, most often depression (Stein & Cyr, 1997). For some women employment may actually be a protective factor, whereas for others it may be a facilitative factor (Ames & Rebhun, 1996).The relationship between alcoholism and anxiety in women has been documented repeatedly, but it remains unclear whether the anxiety conditions are a lifelong disorder or temporary conditions related to intoxication and withdrawal. Women with alcoholism under age 40 are five times more likely to attempt suicide than nonalcoholic women (Centers for Disease Control and Prevention, 1995). The suicide rate for women equals that for men among adults with alcoholism. Stein and Cyr (1997) reported that the following factors are associated with increased risk of alcohol problems in women:

1) drinking to improve psychological function (e.g., shyness, anxiety) in young adulthood 2)low self-esteem in adolescence 3)poor coping skills in adolescence 4)family history of alcoholism (particularly in father) 5)severe premenstrual syndrome 6)concomitant psychiatric diagnosis (depression, anxiety) 7) lifetime use of drugs other than alcohol 8)history of rape or incest 9)fertility problems 10)heavy-drinking partner 11)sexual dysfunction 12)eating disorders 13)low utilization of prenatal care 14)domestic violence 15) suicidality

Women who are heavy drinkers are less likely to use contraceptives and more likely to engage in unsafe sexual practices (Canterbury & McGarvey, 1999). Important gender differences exist in the physiological effect of alcohol. Women become intoxicated after drinking smaller quantities of alcohol compared to men (Brady & Randall, 1999; Blume, 1998), probably because women have lower total body water content than men of comparable size (51% vs. 65%) (Marshall et al., 1983), have lower levels of alcohol dehydrogenase (Frezza et al., 1990), and fluctuations in gonadal hormone levels during the menstrual cycle may affect the rate of alcohol metabolism, making a women more susceptible to elevated blood alcohol concentrations at different points in the cycle (Sutker et al., 1987). Women develop alcoholic liver disease, particularly alcoholic cirrhosis and hepatitis, after a

comparatively shorter period of heavy drinking and at a lower level of daily drinking than men (Hill, 1982; Saunders et al., 1981). Pregnant women who smoke cigarettes run an increased risk of having stillborn or premature infants or infants with low birth weight (Kleinman et al., 1988). Babies whose mothers drink during pregnancy may be born with fetal alcohol syndrome (FAS), which is one of the leading known causes of mental retardation.

Pregnancy influences sexuality, primarily related to the presence of dyspareunia and diminished orgasmic capacity (Oruc et al., 1999). Menopause, with its decline in estrogen and testosterone, may lead to decreased libido (Chiechi et al., 1997), dyspareunia associated with vaginal dryness (Chiechi et al., 1997; Kingsberg, 1998), and other sexual dysfunction. Body image, general health status, psychological issues, relationship status, and beliefs about sexuality, may also influence sexual functioning in the climacteric (Kingsberg, 1998). Sexual functioning in older, postmenopausal women may be influenced by psychological issues of aging, medication, and illness-related factors (Meston, 1997).

Primary sexual dysfunction- In women, sexual dysfunctions include hypoactive sexual desire disorder, sexual aversion disorder, female sexual arousal disorder, and female orgasmic disorder. They also include two sexual pain disorders, dyspareunia and vaginismus. Epidemiological data from the 1992 National Health and Social Life Survey (NHSLS) in U.S. adults (1,749 women and 1,410 men) indicated that sexual dysfunction was more prevalent in women (43%) than in men (31%), with different patterns of sexual dysfunction between genders (Laumann et. al., 1999). Younger women reported more problems with sexual desire and difficulty achieving orgasm than did older women. Nonmarried women reported orgasm problems at 1.5 times the prevalence rates in married women. Women with lower educational attainment described less pleasurable sexual experiences and higher levels of sexual anxiety than did women with higher educational attainment. Poor physical health was correlated with sexual pain in women in the NHSLS. In the Dunn et al. (1998) report, dyspareunia was found to decrease with age.

Personality Disorder (PD)

Nurnberg et al (1999) found that females are predominantly sociable, need relationships, undervalue themselves, sensitive to criticism, self-sacrificing, and emotionally expressive with a more adaptive and autoplastic mode of functioning. There may be underreporting of rates of female juvenile delinquency and biases exist in beliefs about how an adolescent girl demonstrates antisocial behavior (thought to be manifesting itself as precocious sexual activity) and that women are less violent (Pajer, 1998). Although the most common pathological outcome for boys with

antisocial behavior has been shown to be adult criminality, the adult course for girls has been assumed to be more benign. Rutherford et al. (1999) found a weak relationship between the childhood and adult antisocial behaviors seen in women. Work by Caspi et al. (1993) indicates that precursors of antisocial behavior in women may be more closely related to the early taking on of adult roles and norm-breaking behaviors as a way of obtaining adult possessions (e.g., money, clothes, drugs). Pajer (1998) found that childhood maltreatment is a risk factor for adult Antisocial PD (ASPD) in males but not in females. Boderline PD (BPD) is commonly assumed to be more prevalent in women. Zanarini et al. (1997) identified four significant predictors of a BPD diagnosis: female gender, sexual abuse by a male noncaretaker, emotional denial by a male caretaker, and inconsistent treatment by a female caretaker. Paris (1997) has reviewed the phenomenology, behavioral symptoms, epidemiological studies, risk factors, outcome, and treatment of BPD and ASPD and concluded that "similar traits in men and women can have different behavioral expression..... Impulsivity in men is more likely to be expressed through exploitation of others, whereas impulsivity in women is more likely to be expressed in self-destructive behaviour".

PSYCHIATRIC ASPECTS OF THE REPRODUCTIVE CYCLE

The Menstrual Cycle

Premenstrual syndrome (PMS)

PMS is characterized by a pattern of emotional, behavioural and physical symptoms (minor mood changes, breast tenderness, bloating and headache) that occur premenstrually and remit after menses (WHO, 1996). Epidemiological surveys have estimated that as many as 75% of women with regular menstrual cycles experience some symptoms of PMS (Johnson, 1987). Majority of these women do not require medical or psychiatric intervention. For women who have mild to moderate symptoms of PMS, conservative treatments are appropriate, and management without pharmacological interventions should be encouraged.

Premenstrual Dysphoric Disorder (PMDD)

PMDD, consisting of extremely distressing emotional and behavioural symptoms (irritability, dysphoria, tension and mood lability), affects 3-8% of women of reproductive age (Ramacharan et al., 1992). These women report premenstrual symptoms, primarily mood symptoms that are severe enough to interfere seriously with their lifestyle and relationships (Freeman et al., 1985; O'Brien et al., 1995). However, in general, women with PMDD do not respond to conservative interventions. Serotonergic antidepressants have greater effectiveness for treatment of PMDD than nonserotonergic antidepressants.

Prementrual Exacerbation

The category of "premenstrual exacerbation" denotes the premenstrual worsening of a major psychiatric disorder or of a medical condition. Women with continuing psychiatric disorders like major depression, dysthymic disorder, bipolar disorder (especially rapid-cycling type), anxiety disorders, schizophrenia, bulimia nervosa, and substance abuse, reported premenstrual exacerbation of symptoms and sometimes an emergence of new symptoms (Hendrick et al., 1996; Yonkers, 1997; Blehar et al., 1998).Women who manifest severe physical symptoms or a psychiatric disorder with premenstrual exacerbation should be treated for their primary condition.

Menstrual Psychosis

In some women, transient psychotic symptoms may appear in rhythm with the menstrual cycle.

Several features delineate menstrual psychosis (Brockington, 1998), viz,

· Acute or sudden onset, against a background of normality.

· Brief duration, with full recovery.

· Psychotic features (i.e., confusion, delusions, hallucinations, stupor and mutism, or a manic syndrome).

· A circamenstrual (approximately monthly) periodicity, in regular relation with the menstrual cycle.

Treatment for menstrual psychosis have included ovariectomy, hormonal supplementation, endocrine therapy, clomiphene, phenytoin, or acetazolamide.

Pregnancy

Psychiatric illnesses, particularly mood and anxiety disorders, are common in women and typically emerge during the childbearing years (Kessler et al., 1993). Recent data reveal high rates of relapse during pregnancy with recurrent mood disorders in women who discontinue pharmacological treatment during pregnancy (Viguera et al., 2000). Recent studies have found an association between maternal depressive symptoms and preterm birth, lower birth weight, smaller head circumference, and lower Apgar scores (Orr & Miller, 1995; Steer et al., 1992; Zuckerman et al., 1990). Pregnant women with depression are also more likely to smoke and to use either alcohol or illict drugs (Zuckerman et al., 1989), which further increase risk to the fetus children of depressed mothers are more likely to have behavioral problems and to exhibit disruptions in motor, cognitive, and emotional development (-Murray & Cooper; 1997; Weinberg & Tronick, 1998). All psychotropic medications diffuse readily across the placenta, and no psychotropic drug has been approved by the U.S. Food and Drug Administration (FDA) for use during pregnancy.

Major depression- Studies suggest that about 10% of women suffer from depression during pregnancy (O'Hara, 1986). Risk factors for antenatal depression include a personal history of mood disorder, a family history of depression, marital discord, poor psychosocial supports, recent adverse life events, and unwanted pregnancy (Gotlib et. al., 1989; Stewart, 2005).

Bipolar Disorder- The postpartum period has been clearly defined as a period of risk for women with bipolar disorder (Klompenhouwer & van Hulst, 1991), but the impact of pregnancy on the course of bipolar disorder has not been well characterized.

Panic Disorder - Pregnancy may ameliorate symptoms of panic in some patients and may provide an opportunity to discontinue medication (Cowley & Roy-Byrne, 1989). Other studies have noted the persistence or worsening of panic symptoms during pregnancy (Cohen et al., 1994, 1996).

Obsessive-compulsive disorder-For patients with preexisting obsessive-compulsive disorder (OCD), symptoms appear to worsen during pregnancy and the postpartum period (Buttolph & Holland, 1990; Sichel et al. 1993).

WOMEN AND THE SOCIOCULTURAL SCENARIO

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

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

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

Violence

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

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

Education

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

CONCLUSION

In the discussion of the determinants of poor mental health of women, it has become imperative to move from a focus on individual and lifestyle risk factors to a recognition of the broader, economic, legal and environmental factors that affect

women's lives and constrain their opportunities to control the determinants of their health. The identification and modification of the social factors that influence women's mental health holds out the possibility of primary prevention of certain mental disorders by reducing their incidence. It is essential to recognize how the socio cultural, economic, legal, infrastructural and environmental factors affect women's mental health. Only by responding to the complexities and particularities of women's lives can health promotion strategies hope to increase the opportunities women want and need to control the determinants of their health.

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