E**xamining Women’s Health through a Psycho-Social lens**

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***Abstract***

*In the recently concluded COPSAH Global Symposium 2019, a group of therapist and mental health practitioners tried to highlight the issue of women’s mental health with two specific focuses, one being lived experiences of persons living with mental illness and the secondary burn-out and shame faced by their care takers. The other session was to explore the contours of somatisation that is often seen in the human body as a result of onslaught of trauma. The participants reflected on the value of lived experiences and discussed the challenges in getting representation from people with lived experiences (PWLE). The challenges that were listed by the participants were especially around the participation and representation of persons living with intellectual disability and psychosocial disability. Somatisation of traumatic experiences needs recognition in a country like India where women’s life-stressors exist right from childhood that keeps her at thresholds of mental illness and/or psychosomatic illnesses. Psychosocial health issue is relegated to a subordinate category of discussion while public health, reproductive health and health rights are in the mainstream discussions in various seminars, researches and conferences in India. This paper is based on two sessions of the COPSAH Global Symposium 2019 and it focusses on gender and psychosocial dimensions of health from the framework of women being subjected to silently bear the brunt of unpaid care work through social and reproductive labour and the life stressors of women that result in psycho-social distress. Towards this end it is important to build a community of practitioners that looks beyond reproductive health of women. Practitioners and researchers would have to work together to de-condition societies, communities and women at the collective level and at an individual level to be able to voice the importance of women’s good health and wellbeing throughout the life cycle whether she indulges in her reproductive function or otherwise.*

***Keywords****: Women’s health, somatisation, psycho-social wellbeing*

1. ***Introduction***:

It is still a taboo in India to seek support for mental health distress. In a nationwide survey on mental illness in India, it estimated that about 150 million adults over the age of 18 years need mental health care (NIMHANS & MoHFW 2016). As the Sustainable Development Goals (SDGs) have generically clubbed mental illness under non- communicable diseases and substance abuse, it draws attention to the need of considering socio-political-cultural contexts of people with psycho-social disabilities. Women with psychosocial disabilities (PSD) face greater vulnerability and are subjected to increased stigma and discrimination, additionally it is women who face greater barriers in the exercise of their political and civil rights.

According to the World Health Organisation (WHO), gender differences are seen in the prevalence rates of common mental disorders that are depression, anxiety and somatic complaints. It is understood that women predominate in numbers in common mental disorders and is considered to constitute a serious public health problem. In the Practitioner’s huddle during the symposium, a participatory session outlined the importance of listening to people with lived experience of PSD and engaging with them in community-based prevention and therapy practices.

The practice based COPASAH Global Symposium had a session to understand somatic repercussions of stress and trauma especially for women that arise due to women’s life stressors. One of the major stressor of unpaid care work that is common is always overlooked. The annual study of wealth inequality worldwide released by Oxfam in the run up to the Davos World Economic Forum points out that in India, unpaid work done by women looking after their homes and children is worth 3.1 per cent of the country's GDP (Business Today 2019). The report further adds that in comparison to men who spend only 29 minutes in urban and 32 minutes in rural areas on unpaid care work, women spend 312 minutes per day in urban areas and 291 minutes per day in rural areas. It is no surprise then that studies show the prevalence rates of many musculoskeletal pain conditions to be higher among women than men; additionally having multiple pain conditions is associated with higher levels of disability and psychological distress than having a single pain condition (Leresche 2011). Despite knowing this we have not yet been able to correlate the relationship between women’s physical pain and the burden of unpaid care work.

Psychosocial health issue is relegated to a subordinate category of discussion while public health, reproductive health and health rights are in the mainstream discussions in various seminars, researches and conferences in India. This paper is based on two sessions of the COPSAH Global Symposium 2019 and it focusses on gender and psychosocial dimensions of health from the framework of women being subjected to silently bear the brunt of unpaid care work through social and reproductive labour and the life stressors of women that result in psycho-social distress.

2. ***Psychosocial health and care giving:***

In the recently concluded COPSAH Global Symposium 2019, a group of therapist and mental health practitioners tried to highlight the issue of women’s mental health with two specific focuses, one being lived experiences of persons living with mental illness and the secondary burn-out and shame faced by their care takers. This session was facilitated by experienced persons and public health experts working on community mental health that included the author. The Emmanuel Hospital Association (EHA) located in Uttarakhand state of India presented their work on community mental health. The other session was to explore the contours of somatisation that is often seen in the human body because of onslaught of trauma.

A short film made by the EHA showed how a toolkit that was developed jointly with People with lived experiences (PWLE) and the implementation of the same through a participatory approach made it highly effective. The participants reflected on the value of lived experiences and discussed the challenges in getting representation from PWLE. The challenges that were listed by the participants were especially around the participation and representation of persons living with intellectual disability and psychosocial disability. Some participants shared actual examples of positive input in the implementation of community-based rehabilitation of psychosocial disability along with the challenges for participation. Most often the agency of persons living with a psychosocial illness is taken for granted, however this session was extremely helpful in understanding this concept of ‘agency’. The value of participatory mechanisms in community-based implementation of mental health program was emphasised and input of such examples into policy was recognised.

3. ***Somatisation and psychosocial health***

The other session in the Symposium focused on mental health especially that of women and also dealt with how the body holds trauma which further manifests into disabilities of sorts. This session was a special performance based facilitated discussion on somatisation and ‘wellbeing’ was facilitated by an experienced psychotherapist who uses public performances as the medium for these discourse and was co-facilitated by the author. The performance focussed on the idea to delve into the wisdom of the body, how that's available to us and whether we allow the body to communicate with us or let the mind take over. This followed an elaborate discussion on how various societal norms govern the life of women, be it through the body or the performance of the body.

The social framework that validates women’s existence is primarily through her body. The ability to do care-work and bear children, the physical appearance in notions of traditional beauty and her demeanour to bodily subjugate herself to the ownership of men, are the essentials of this framework. Studies in the global north show that although women have more physical pain compared to men, the paradox is that women’s pain reports are taken less seriously (Hoffman & Tarzian 2001). Methods of controlling and assisting women’s reproduction by manipulating their bodies are the common practice of the public health system in India. The overt focus on Women’s Reproductive and Maternal (& Child) Health further brings the body in control of the State and patriarchal forces.

3.1 *Aches, pains and shame*

The discussion that pursued after the performance in the session focussed on various aches, pains, burning sensations and shame associated with the physical body that is so often overlooked for women. Somatization of traumatic experiences needs recognition in a country like India where women’s life-stressors exist right from childhood that keeps her at thresholds of mental illness and/or psychosomatic illnesses. By 2020 the second leading cause of global disability will be unipolar depression and it is twice as common in women. Further research is needed to confirm that depression is not only the most common women's mental health problem but may be more persistent in women than men states WHO.

Domestic violence, sexual violence, emotional violence at workplace all need to be considered while understanding how a woman holds her own body (image) in her mind and how this could relate to diseases like chronic pain. Therefore, while dealing with women’s health and well-being it is imperative to holistically understand a woman’s physical and psycho-social wellbeing keeping various factors in mind. Since the focus on non-reproductive health of women is so low, plus minimisation of the same happens, it would be important to understand body pain from a trauma-informed standpoint (Matchinger 2019).

It is commonly observed that women who face higher degrees of physical violence with the additional burden of doing household work that stresses the body have chronic back pain, neck pain and knee pain. However, there are very few studies in India that correlate these factors to understand women’s overall health and wellbeing.

*3.2 Exposure to violence*

It has been understood that most often families are the sites of sexual violence of girls/boys and women, in coexistence with physical violence and it is in this space (families) that the perpetrators lurk and are provided shelter. In a recent work on Masculine Norms and Violence, the authors talk about how hegemonic order of masculinity “contribute to an inequitable and oppressive distribution of status and power, often policed and patrolled by state-sanctioned violence” (Heilman & Barker 2018). Significantly it has been found that women exposed to physical or sexual violence were more likely to report somatic symptoms. Globally Intimate Partner Violence (IPV) is considered a significant global public health problem (Alangea 2018).Exposure to violence has been shown to have an impact on somatic health. Although very few studies are conducted in India around somatisation, it is understood from studies conducted in the West that violence was associated with the presence of somatic symptoms and diseases, they reiterate that complaints such as stomach pain, back pain, pain in arms/legs/joints, menstrual pain/problems, pain/problems during sexual intercourse, headache, chest pain, dizziness, fainting spells, feeling your heart pound or race, shortness of breath, constipation/loose bowels/diarrhoea, feeling tired/ having low energy, and trouble sleeping are somatic symptoms. These symptoms increase or intensify when a woman is exposed to more and more violence (Eberhard 2007).

In a country like India where almost every woman has experiences of Childhood Sexual Abuse with differing degrees of intensity and duration, it is therefore not uncommon that somatisation can occur. Further drunkenness and alcohol misuse by the male partner are associated with poor mental health and spousal violence among married women in India. In a study conducted amongst women in Goa around this subject it was seen that attitudes condoning male spousal violence were independently associated also with mental health problems in women. This was a population study on alcohol use patterns and sexual risk behaviours conducted in rural and urban areas in Northern Goa, with women aged 18–49 years (Nayak et.al. 2010).

4. **Beyond reproductive health**

While it is recognised that gender equity is a human right by UNFPA, the focus on women's health issues are dominated by reproductive health and/or sexual and reproductive health. While reproduction is a predominant function in a woman’s body, there are other health issues that she faces. As per WHO estimates, depression is expected to be the second largest contributor to disease burden by 2020; specifically stating that one in every three women worldwide will be afflicted by common mental disorders including depression. While ante-natal services, maternal health care and safe deliveries are the right of every women, the cost of reproductive labour and unpaid care work is on her body’s non-reproductive functions as well.

Shame associated with a women seeking well-being is so high, that even educated women in India are unable to understand that living in stressful conditions of physical/psychological (domestic) violence or having traumatic history from childhood could make them susceptible to Post traumatic Stress disorders (PTSD). As feminist theorists have argued, women's well-being is not solely determined by biological factors and reproduction, but also by the effects of workload, nutrition, stress, war and migration (Boddy 1989), it is important to start examine the interrelations of such manifestations. Links between economic hardship, child death, emotional deprivation, and psychological distress in women have also been documented in many anthropological studies (Cohen 1997).

**5. Building Community Solidarity**

The Global Symposium provided a space to open up an often understudied and undiscussed issue of women’s health and wellbeing. Studies to engage deeply with various determinants of health from a gendered perspective is needed that would enhance the understanding of the interconnectedness of women’s overall health and wellbeing to life stressors. Towards this end it is important to build a community of practitioners that looks beyond reproductive health of women.

Interestingly in a study conducted amongst women to understand how they perceived their illness and weakness, it was found that women attribute it to poverty, overwork, not enough food, neglect and increased violence resulting in poor physical and mental health conditions (Shodhini 1997). Trivialisation of women’s experiences of physical pain is also internalised by women who consider talking about their pain as a stigma. (Pachauri et al 2011). Practitioners and researchers would have to work together to de-condition societies, communities and women at the collective level and at an individual level to be able to voice the importance of women’s good health and wellbeing throughout the life cycle whether she indulges in her reproductive function or otherwise.

The EHA intervention shows that a participatory approach is extremely effective in dealing with community co-responsibility in specific reference to PWLE. It could also be perhaps understood that society values a women who is productive both by bearing children and doing unpaid care work. Hence it is worthwhile to examine whether acknowledging women’s illness that call for changes in gender roles might threaten the larger society. As the global community of practitioners, we have to comes together in solidarity to recognise, write and create narratives and lay the foundation for gender-equal societies were women are healthy and live a life devoid of bodily shame and despair.

**REFERENCE**:

1. Alangea, D. O., Addo-Lartey, A. A., Sikweyiya, Y., Chirwa, E. D., Coker-Appiah, D., Jewkes, R., & Adanu, R. M. K. (2018). Prevalence and Risk Factors of Intimate Partner Violence among Women in four Districts of the Central Region of Ghana: Baseline Findings from a Cluster Randomised Controlled Trial. PLoS One, e0200874
2. Boddy, J. (1989). Wombs and Alien Spirits: Women, Men, and the Zar Cult in Northern Sudan. Madison, WI: University of Wisconsin Press.
3. Business Today, [www.businesstoday.in/wef-2019/news/women-unpaid-work-worth-43-timesthe-annual-income-of-apple-world-biggest-company-report/story/311941.html](http://www.businesstoday.in/wef-2019/news/women-unpaid-work-worth-43-timesthe-annual-income-of-apple-world-biggest-company-report/story/311941.html)
4. Cohen, A. (1997). Site Visits. Updates on Global Mental and Social Health 2:1.
5. Eberhard-Gran, M., Schei, B., & Eskild, A. (2007). Somatic symptoms and diseases are more common in women exposed to violence. *Journal of general internal medicine*, *22*(12), 1668-73
6. Heilman B. & Barker G. (2018). Masculine Norms and Violence: Making the Connections. Washington, DC: Promundo-US.
7. Hoffmann D. E. and Tarzian A. J. (2001). “The girl who cried pain: a bias against women in the treatment of pain,” *Journal of Law, Medicine & Ethics*, vol. 28, no. 4, pp. 13–27, 2001.
8. Leresche L. (2011). Defining gender disparities in pain management. *Clinical orthopaedics and related research*, *469*(7), 1871-7. 1
9. Machtinger E L, Davis K B, Kimberg LS, Khanna N, Cuca Y P, Dawson-Rose C, Shumway M, Campbell J, Lewis-O’Connor A, Blake M, Blanch A, McCaw B. (2019). From Treatment to Healing: Inquiry and Response to Recent and Past Trauma in Adult Health Care,Women's Health Issues, Volume 29, Issue 2,2019, Pages 97-102, ISSN 1049-3867, <https://doi.org/10.1016/j.whi.2018.11.003>.
10. National Institute of Mental Health and Neurosciences (NIMHANS) and MHFW Government of India (2016). National Mental Health Survey of India, 2015-16. Bengaluru: NIMHANS.
11. Nayak, M., Patel, V., Bond, J., & Greenfield, T. (2010). Partner alcohol use, violence and women's mental health: Population-based survey in India. *British Journal of Psychiatry, 196*(3), 192-199. doi:10.1192/bjp.bp.109.068049.
12. Pachauri S, Gittelsohn J, Bentley M E, Pelto P J, Nag M (2011). Listening to Women Talk About their Health: Issues and Evidence from India; The Ford Foundation, Har-Anand PublicationsPvt. Ltd.
13. Shodhini (1997). Touch me, Touch-me-not- Women, Plants and Healing, Kali for Women, New Delhi.