The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 11, Issue 3, July- September, 2023
DIP: 18.01.121.20231103, DOI: 10.25215/1103.121
https://www.ijip.in

Review Paper

Women's Mental Health: A Narrative Review

Dr. Jayesh Ghodke[1], Neoshi Vora[2]*, Akanksha Gupta[3]

ABSTRACT

Women face a number of issues in life. We live in a predominantly patriarchal society where women have to struggle a lot for things that men take for granted. Talking about a place like India, where some backward practices and mindsets still prevail, women have an even more difficult time. While both mental health and the place of women in society have been gaining more and more importance day by day, the conditions are still not ideal and there is a long way to go. There has been a lot of research on the specific issues that women face however there is a gap for comprehensive reviews that include most issues, especially from an Indian perspective. This article intends to fill that gap.

Keywords: *Women, Mental Health, Indian Women*

Mental health is a term used very often these days, and as time goes by, it is beginning to gain more and more precedence. People in the West give as much importance to their mental health and well-being as compared to their physical health, and while this is an amazing feat that was thought to be impossible until a few years ago the same cannot be said about the East. The West is more advanced than the East in many aspects and mental health is no exception to this. When we talk about countries like India where people are still struggling to fulfil their basic needs of food and shelter, mental health is not a priority, most people who suffer from issues with their physical health also struggle to find the appropriate resources for treatment.

There is a huge need for infrastructure that addresses the needs of the people free of cost or at a subsidised rate. And only when these needs are fulfilled can people move on to the next level. Mental illnesses are on the rise in India, industrialization and modernization have led to a shift in family structure from joint to nuclear and more and more people are moving away from their families for work and education. This along with interactions getting more and more impersonal has led to a shift in the lives that were previously collectivistic. In addition to that, there has also been a change in family roles and dynamics, due to more and more women choosing to work. These new social roles, with additional responsibility without any division of labour at home, has led to increased stress for women.

[1]Consultant Psychiatrist, Dept. of Psychiatry, Dr. R.N. Cooper Municipal General Hospital, Juhu, Mumbai
[2]Bachelor of Arts (Psychology), SVKM's Mithibai College of Arts Chauhan Institute of Science and Amrutben Jivanlal College of Commerce and Economics, Vile Parle West, Mumbai
[3]Clinical Psychologist, Dept. of Psychiatry, Dr. R.N. Cooper Municipal General Hospital, Juhu, Mumbai
*Corresponding Author

Received: May 24, 2023; Revision Received: July 25, 2023; Accepted: July 30, 2023

Women are biopsychosocial beings, who are inherently different from men. Women are relationship-oriented people, they grow for and through relationships. The approach to understanding the workings of the minds of women and the workings of the minds of men is completely different. In the field of psychology there has been a bias when the behaviour of men has been treated as the gold standard and the behaviour of women is deviant. Women are more prone to mental illness because of their social duties and responsibilities. They are also more likely to suffer from sexual assault, rape, workplace harassment, caretaker responsibilities, poverty and eating disorders. Women also have the tendency to ruminate which is mentally repeating what has happened and pondering about why and how it has been linked to depression, men on the other hand tend to choose more action-packed ways of coping.

The patriarchy still prevails in India and women are under their fathers first and then at the mercy of their husbands. Women are expected to take responsibility for household chores and child-rearing regardless of whether they are working or not. But in the case of homemakers, this is their only job and they have no external sources of fulfilment other than their husbands and children. They are also financially dependent on them and this causes problems in the long term and affects relationship dynamics.

RATIONALE

While there has been a lot of research on specific issues that women face, there is dearth of research on comprehensive reviews that cover a number of factors. This review attempts to review articles on a range of topics like domestic violence, sexual harassment, workplace harassment, postpartum depression, perinatal depression, eating disorders, the effect of the pandemic and many more. These topics have been picked specifically as there are one of the many factors that affect the mental health of women. This paper aims to examine these topics and discuss them from an Indian point of view, with suggestions to improve the mental health of women in India.

SEARCH STRATEGY

A literature review was carried out to regard "Women's Mental Health" for pertinent publications between January 2012 and May 2023 using Google Scholar and various electronic databases. Publications that were listed under the search terms "mental health", "women", "anxiety", "sexual assault", "domestic violence", "eating disorder", "anxiety", "depression", and "workplace harassment" were checked. Searches for related studies in an Indian context were conducted. The bibliography of the studies on the connected subjects was also used to filter further published material.

REVIEW OF LITERATURE

Since this research is being conducted from an Indian perspective it would be remiss to not mention how Indian culture, practices and mindset influence the mental health of women.

Niaz and Hassan examine how cultural variables affect South Asian women's mental health. Women now have a second-class status in South Asia due to pronounced gender discrimination. They appear to be dependent on the male members of a patriarchal society for their mobility, employment, self-esteem and self-image, in fact, their worth and identity. Women's lack of self-determination and emotional and financial reliance have limited their ability to express themselves and their range of options in life. This has a real effect on women's mental health, combined with pressures from their families, friends, and jobs. The most populous and one of the poorest regions in the world is South-East Asia. Large-scale

inequality, violence, political unrest, and a high prevalence of diseases are just a few of the huge social, economic, and health difficulties it faces. When women's health has been discussed in this area, efforts have typically concentrated on issues related to reproduction, such as family planning and childrearing, with women's mental health receiving relatively little attention. Most of the societies in South-East Asia are primarily patriarchal. According to popular belief, boys are created to work and provide for the entire family while ladies are intended to be fed throughout their lives. This idea is represented in some of the discriminatory actions people take. Even among very impoverished households, the birth of a baby boy is fervently celebrated, and they seek any opportunity for celebration on the occasion of the birth of a male kid, even if they have to take a loan for it. The birth of a girl, however, is not anticipated. In some rural areas of India, where the girls are even denied the right to life, the situation is even worse. India continues to practise widespread sex selection during pregnancy, forcing women to terminate female foetuses. When a woman carrying her newborn daughter returned home from the hospital in one of India's remote villages, her mother-in-law mashed a toxic coriander into a dollop of oil and forced it down the infant's throat. The reasoning behind it was that giving up a daughter ensures a son during the subsequent pregnancy. Senior family members, especially mothers-in-law, frequently pressure the spouses to continue taking chances for the birth of a baby male, which frequently results in the birth of five or six girls.

The cultural traditions that are prevalent in South-East Asia uphold women's economic and social subordination. In this region, young, unmarried girls and women frequently experience extreme physical and mental stress as a result of the violent behaviour of men. Wife-beating, wife-murder, kidnapping, rape, physical assault, and acid-throwing are some of the types of violence. Domestic disputes resulting from a woman's family's failure to pay the dowry at the time of marriage are the most common reasons for violent crimes.In addition, a lot of South-East Asian women and young children are trafficked and coerced into prostitution, arranged marriages, and bonded labour. Sexual exploitation of women is encouraged and sustained by illiteracy, political forces, a feudal and tribal culture, ignorance and distortion of religious precepts, and, most importantly, a girl's poor place in society. Employers, brothel owners, and even law enforcement officers might use violence, intimidation, rape, and torture against the victims of human trafficking. Overt coercion, physical abuse, emotional blackmail, deprivation of resources, social exclusion, and threats of death are used to sustain this sexual servitude. It is common to cite traditions and customs to defend against violent behaviour.

A meta-analysis of 13 epidemiological studies conducted in various parts of India found that 64.8 per 1000 women worldwide had a mental condition. Neuroses, affective disorders, and organic psychoses were substantially more common in women than in men. Psychiatric morbidity was found to be higher in women than in males. According to a study done, financial dependence (10%), lack of a meaningful job (14%), marital conflicts (25.5%), in-law disputes (13%), stress from household and employment-related tasks (9%), and marital conflict (25.5%) are all risk factors for depressive disorders in upper and middle-class women. Conflicts with husbands and in-laws were found to be the most common causes of women committing suicide, according to a different study done in the same nation. Due to the fact that the system accepts these acts of abuse as legitimate, women who experience domestic violence from their husbands and in-laws are helpless. Since it is a domestic conflict, the police and other law enforcement organisations are typically reluctant to become involved. If the woman decides to end her marriage, she will have to deal with a plethora of issues, including social rejection, financial restraints, and the psychological

effects of her children growing up without a father. Women are more prone to depression while under stress due to their propensity to internalise their suffering and stress, as well as to their inferior social standing and lack of environmental control. It is widely acknowledged that employment generally improves psychological health. Along with cash, social position, and social contacts, it also gives interest, fulfilment, structure, and a sense of control. Fewer options for women to work at paid occupations exist in South-East Asia, which has an impact on their mental health. According to a recent population-based survey from India, nearly half of women reported experiencing physical assault, assault has reached alarming proportions in some parts of SouthEast Asia. Most South Asian nations have the belief that only women are responsible for bearing children, and as a result, guilt for not having the necessary number of children is unquestionably placed on them, destabilising their social standing. Working women in South-East Asian nations have also been found to experience high rates of mental anguish; cultural factors are among the causes. Most of the time, this mental distress goes unrecognised. Lastly, a spike in the frequency of reported rape, domestic violence, and alcohol misuse has been observed in South-East Asia as a result of recent economic reforms.

A systematic review was conducted to outline the frequency of marital rape in India, the analytical techniques used in its investigation, and its effects on victims' mental health. Depression and Post Traumatic Stress Disorder (PTSD) are the main outcomes of interest. Suicidality and other secondary PTSD and depression outcomes that were included in the selected studies were also described. After removing research based on our selection criteria, 11 studies—9 quantitative and 2 qualitative—were included. The prevalence of marital rape ranged from 2% to 56%, while sexual coercion by an intimate partner ranged from 9% to 80%. Numerous research found statistically significant links between marital rape and results in terms of mental health, including severe depression (7 of 8 studies) and PTSD (1 of 3). Using the NIH Quality Assessment Scale and the modified Newcastle Ottawa Scale for cross-sectional and observational cohort studies, quantitative studies were evaluated for quality and bias risk, and the majority showed a low risk of bias. A low to moderate correlation between marital rape and poor mental health outcomes has been shown, in order to develop health infrastructure and policy, more study is required to understand marital rape's prevalence and effects.

Now that the culture specific issues have been discussed, let's look at issues that are universal. Domestic violence, sexual assault, workplace harassment are prevalent in all parts of the world.

Domestic violence is a huge concern for women and Roberts, Lawrence et al conducted research studying the mental health of women who had been victims of domestic abuse. This longitudinal study measured anxiety, depression, phobias, dysthymia, drug dependence and alcohol dependence in women who had been abused and those who hadn't experienced any abuse. Both groups were also tested for PTSD. 23% of Australian women have experienced physical violence in a relationship at some point or the other and 9% of women who are currently in relationships have experienced abuse in either physical or emotional form. A large percentage of women also currently live in fear because of their past experiences. Past research in this area has focused on the physical injuries sustained by the victims but there has been very little research on the long-term mental and emotional effects of abuse. This study also makes the links between childhood and adulthood double abuse and its implications. The study used a sample of 335 women from the Royal Brisbane Hospital's emergency department with a mean age of 45.5 years. 16 to 74 age groups, a screening

questionnaire followed by an in-depth interview were used to gather data. Composite abuse scale (CAS) a self-report questionnaire was used to measure the intensity and frequency of abuse. It contains of statements regarding physical, emotional, and sexual abuse and harassment. The CIDI (Composite International Diagnostic Interview) by the World Health Organisation was used for the diagnosis of depression, dysthymia, anxiety, substance abuse, phobias, sexual dysfunction and somatization. It is a structured interview. The Composite International Diagnostic Interview PTSD module is another such structured interview that measures PTSD. The PTSD Checklist and Alcohol Use Disorders Identification Test were also used to gather data. Talking about the demographic details, most women who enter the Emergency Department of the hospital belong to lower socio-economic strata. Data analysis was conducted using SPSS, and chi-square two-tailed tests were conducted to compare the characteristics of women who had been abused and the women who hadn't been abused, regression analysis was conducted and confounding factors of age, occupation, marital status and country of birth were controlled for. Results are based on 335 women's baseline interviews. 162 (48.5%) of the 335 women who took the CAS test and provided a history of adult domestic violence. Forty-one (12.3%) who did not report domestic violence on the screening questionnaire answered positively on the subsequent CAS, and only 10 women (3.0%) who reported domestic violence on the screening questionnaire answered negatively on the CAS. The screening questionnaire demonstrated 75% sensitivity and 94% specificity for reporting domestic abuse in comparison to the CAS.

Uncertainty exists regarding the association between partner alcohol consumption and violence as risk factors for women's poor mental health. To define partner-related and other psychosocial risk factors for common mental disorders in women and analyse interactions among these factors, Nayak Patel et al. conducted research. 821 women between the ages of 18 and 49 who were part of a broader demographic research in north Goa, India, made up the sample. In order to test for mediation effects in the association between partner alcohol use and these illnesses, logistic regression models were used to assess the risks for common mental disorders in women.

The likelihood of common mental diseases was elevated by two to three times when partners drank excessively. The relationship between spouse's excessive alcohol consumption and these mental disorders was somewhat mediated by both partner violence and alcohol-related issues. Independently linked to them were women's personal views towards violence. To prevent and cure common mental disorders in women, issues like partner drinking, partner violence, and women's attitudes towards violence must be addressed.

During their college years, one in five female students report non-consensual, unwelcome sexual contact. First-year college women are most likely to be sexually assaulted. According to one study, rates of recent unwanted sexual contact peaked in the first year (17%) before falling to 11% of seniors. First-year women are allegedly in a "red zone" for heightened risk of sexual assault, according to researchers. The red zone effect applies to all types of sexual assault; for instance, in a sample of women from 22 colleges, first-year students were 2.0 to 4.6 times more likely than their older peers to experience sexual assault that was facilitated by drugs and alcohol as well as attempted or successful forcible rape.

According to a German longitudinal study of first-year students, baseline depression and prior sexual assault were the only factors that might predict future depression and sexual assault in the student's second and third years. When students were examined in their third year of college, however, despite controlling for these baseline predictors, sexual assault in

the first year also significantly predicted depressive symptoms. This research emphasises the value of longitudinal designs. Such long-term investigations have not yet been carried out employing a sample from the United States.

Mushtaq, Sultana et al conducted research on The Trauma of Sexual Harassment and its Mental Health Consequences Among Nurses. The purpose of this study was to ascertain the prevalence of sexual harassment among nurses and to examine the relationship between it and poor mental health (depression, anxiety, and stress). To further investigate the function of sexual harassment as a predictor of poor mental health in nurses and to investigate the disparities in how young and senior nurses perceive sexual harassment, depression, anxiety, and stress.

A cross-sectional descriptive research design was used and nurses from Public Sector Hospitals in Lahore, Pakistan, from December 2011 to March 2012 were asked to be a part of the study.

200 nurses between the ages of 23 and 46 comprised the sample. The Sexual Harassment Experience Questionnaire (SHEQ) by Kamal and the Depression, Anxiety, and Stress Scale (DASS) by Lovibond and Lovibond were both employed as assessment instruments in the study. Results: The nurses' average age was 36 years. 37% of them were single, while 63% of them were married. Nurses had an average of 15 years of work experience, and they made an average of 40000 rupees per month. They worked between 8 and 16 hours each day. Sexual harassment was present on average at a rate of 71.66 19.01. Sexual harassment was found to be significantly positively correlated with depression, anxiety, stress, and the sum of those effects (DASS). According to a multiple regression analysis, sexual harassment among nurses was a significant predictor of stress, anxiety, and depression. This research has shown that sexual harassment is a predictor of poor mental health, including depression, anxiety, and stress.

Even though the pandemic is over and life seems to be getting back to normal, it was a major cause of stress to everyone, especially women. We now examine the effects of the pandemic on the mental health of women. Since H1N1, Covid19 is the most severe pandemic. The COVID-19 pandemic has also affected the mental health of the population, especially women. Almeida, Shrestha and al conducted research about the impact of the pandemic on the mental health of women, and how women are especially vulnerable to its adverse effects. Women who are facing intimate partner abuse, are pregnant, have recently given birth, are miscarrying, or are pregnant are most vulnerable to developing mental health issues during the pandemic. Prevention, early detection, and timely treatment could be achieved by proactive outreach to these groups of women and the strengthening of social support. A significant protective factor is social support. Similarly, to this, raising children during a pandemic may be significantly more difficult. Women are disproportionately responsible for the majority of domestic activities, including childcare and eldercare, which may increase gender inequities, especially for working women or single parents.

Thibault et al also conducted research which found that the pandemic has affected women more than men both at home and at work. There was also a spike observed in violence against women during the pandemic. While more men have been affected by and died from Coronavirus, which can be explained by pre-existing health conditions and risk behaviours like smoking and drinking. However, women are more likely to be exposed to the virus because they make up the majority of frontline and essential workers and face additional

demands both at work and at home. The pandemic can be especially upsetting when certain circumstances, including pregnancy, arise. Two cohorts of volunteer pregnant women were compared in a Canadian study. The first was hired before the COVID-19 epidemic, and the second was hired online in April 2020. The only topics of interest in this investigation were distress and mental symptoms. When compared to pre-COVID-19 women, women from the COVID-19 group displayed higher levels of depression and anxiety symptoms. Additionally, it was discovered that women in the COVID-19 cohort who had previously received a psychiatric diagnosis or who were low-income had a higher likelihood of reporting elevated distress and psychiatric symptoms. Furthermore, since the virus may have harmful effects on the foetal brain, we are unsure about the long-term implications of maternal exposure to COVID-19 infection and the risk of future mental disorders in kids. The first instance of a neonate suffering from white matter damage as a result of a Covid-19 infection following transplacental transmission was documented by Vivanti et al. The neonate's hypertonia had improved and the amount of white matter lesions had decreased two months after birth. Early brain damage, though, could make future mental illnesses more likely.

Davenport, Meyers et al conducted research on maternal mental health during the Covid-19 pandemic. One in seven women experience depression or anxiety during the perinatal period, which is linked to an increased risk of preterm delivery, decreased mother-infant attachment, and delays in the infant's cognitive and emotional development. The purpose of this survey was to evaluate the impact of the COVID-19 pandemic and subsequent physical isolation/distance measures on the mental health and physical activity of pregnant and postpartum women.

Women who were expecting or were within a year of giving birth were invited to take an online survey between April 14 and May 8, 2020. This comprised surveys on self-reported levels of anxiety (State-Trait Anxiety Inventory; STAI-State), physical activity, and depression/depressive symptoms (Edinburgh Postnatal Depression Survey; EPDS). For each, the pre-pandemic and current values were evaluated. 380 (42%) of the 900 eligible women were in the first year following birth, and 520 (58%) were pregnant. Sixty-four percent of women reported decreased physical activity following the implementation of isolation measures, 15% reported increased physical activity, and 21% reported no change. An EPDS score >13 (indicative of depression) was self-reported by 15% of respondents pre-pandemic in contrast to 40.7% currently. Before the pandemic, 29% of women reported having moderate to severe anxiety, compared to 72% of women today. It was also discovered that women who exercised for at least 150 minutes per week at a moderate intensity during the pandemic scored considerably lower on tests for anxiety and depression than those who did not.

Pregnancy and child rearing are things a large percentage of women go through. However, these too can have a huge impact on their mental health.

One of the most prevalent side effects of having children is postpartum depression, a mental disease that can be incapacitating but is also treatable. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) of the American Psychiatric Association (APA) classifies postpartum depression as a major depressive episode "with peripartum onset if the onset of mood symptoms occurs during pregnancy or within 4 weeks following delivery". Depression that doesn't fully match the criteria for a major depressive episode or that manifests more than four weeks after delivery, however, may still be harmful and necessitate

medical attention. According to several definitions used in clinical practice and research, postpartum depression (also known as nonpsychotic puerperal depression) is described as depression that manifests within four weeks of giving birth, three months, six months, or up to twelve months after. In lower- and middle-income nations, the estimated prevalence of postpartum depression ranges from 6.5 to 12.9%, and may even be higher. In addition to sleep issues unrelated to baby care, postpartum depression symptoms frequently include anxiety, anger, and a sense of overwhelm as well as an obsessional preoccupation with the baby's well-being and feeding. There have also been reports of suicidal thoughts and newborn safety concerns. A history of mood and anxiety issues, and in particular, untreated sadness and anxiety during pregnancy, is the biggest risk factor for postpartum depression. Although the precise pathogenesis of postpartum depression is unknown, the rapid decline in reproductive hormone levels after childbirth probably contributes to the development of depression in susceptible women in addition to hormonal changes, proposed contributors include genetic factors and social factors including low social support, marital problems, violence involving the intimate partner, prior abuse, and negative life events. Postpartum depression has a diverse natural course. Although it may go away on its own within a few weeks of the onset, 20% to 13% of women with postpartum depression continue to struggle with the condition two years after giving birth, and 40% will experience a relapse either during a subsequent pregnancy or on another occasion unrelated to pregnancy. Postpartum depression causes maternal suffering and reduced functioning, as well as increased risks for marital discord, compromised infant-caregiver attachment, and compromised emotional, social, and cognitive growth in the child. In rare instances, it can also lead to suicide or infanticide.

From a physical-biological perspective as well as from the perspective of a psychological experience, pregnancy is seen as a major event in a woman's life. Since the pregnancy phase, there have been both objective and subjective changes that may cause the mother mild or severe mental problems, such as psychosis, postpartum depression, perinatal depression, and maternity blues. A study conducted a clinical analysis of the state-of-the-art scientific knowledge regarding various perinatal psychopathologies and extreme behavioural responses of a mother towards the child or herself, which are frequently characterised as "fits of madness" and include neonaticide, infanticide/childicide, and suicide. The study examined these phenomena from a clinical and behavioural perspective to inform healthcare workers, staff at social service agencies, and law enforcement that 93% of communication occurs through our bodies. To get a fuller picture, risk factors including the mother's home environment, socioeconomic level, geographic location, parenting style, etc., which if pathological, can encourage her to commit specific crimes, were also taken into account. In the eyes of the general public, pregnancy is a joyful occasion, the pinnacle of femininity, in which only happy feelings seem acceptable because it is not always acknowledged and accepted that a woman may have unhappy feelings. Therefore, if the mother is unable to resolve these conflicting emotional feelings, she will be left in a state of confusion and will likely believe that she is wrong to feel these feelings. She will also likely feel ashamed of them, so rather than seeking assistance, she will likely choose to withdraw and suffer in silence or act overly perfect and protective of the child. Scientific research has shown that the postpartum period is a stressful time for women, marked by noticeable changes (physical, hormonal, psychological, etc.), and as a result, it is a time when mood psychopathology is more likely to occur, having a negative effect on the child, the mother-child bond, and the entire family system. Based on the international literature, mood disorders can be categorised under clinical frameworks that differ in frequency, severity levels, and short- and long-term impacts.

There is little information available on perinatal mental health during the coronavirus disease 2019 (COVID-19) pandemic and its associated factors. Consequently, the goal of this international study was to evaluate the mental health of expectant and nursing mothers during the pandemic and to investigate any connections between depressive symptoms, anxiety, and stress and the sociodemographic, physical health, and reproductive features of women. Between June 16 and July 14, 2020, a cross-sectional, web-based investigation was conducted in Ireland, Norway, Switzerland, the Netherlands, and the UK. Women over the age of 18 who were pregnant or nursing and up to three months postpartum were eligible. Social media and hospital websites pushed the online, anonymous poll. To evaluate the state of one's mental health, the Perceived Stress Scale (PSS), the Generalised Anxiety Disorder seven-item scale (GAD-7), and the Edinburgh Depression Scale (EDS) were employed. To find the factors linked to poor mental health, regression model analysis was utilised. 9041 women took part in all, including 3907 pregnant and 5134 nursing mothers. In the sample of women who were pregnant and nursing, the prevalence of major depressive symptoms (EDS 13) was 15% and 13%, respectively. 11% and 10%, respectively, of pregnant and nursing women showed moderate to severe generalised anxiety symptoms. Chronic mental illness, chronic somatic illness in the postpartum period, smoking, an unexpected pregnancy, professional status, and residence in the UK or Ireland were risk factors linked to poor mental health. Conclusions: During the COVID-19 outbreak, pregnant and nursing women experienced significant levels of generalised anxiety disorder and depressive symptoms. To protect maternal and baby mental health during pandemics and other societal crises, the study's findings highlight the significance of monitoring prenatal mental health.

Women are especially susceptible to depression and anxiety symptoms during the perinatal period because it involves considerable physiological and psychological changes. Additionally, the continuing coronavirus disease 2019 (COVID-19) pandemic is probably going to make people more vulnerable and make mental health issues more common.

This review intended to look into the existing research on the psychological effects of the COVID-19 pandemic on pregnant women and the first year after giving birth. According to the examined contributions, the COVID-19 outbreak had a moderate to severe influence on pregnant women's mental health, particularly a considerable rise in depression (up to 58% in Spain) and anxiety symptoms (up to 72% in Canada). Along with the typical psychiatric signs and symptoms, concerns about COVID-19's potential impact on pregnancy and the welfare of the unborn child surfaced. The impacts of the pandemic on mother mental health appear to be able to be tempered by social support and frequent physical activity, two protective factors. Conclusions: Despite the study's design constraints, the results point to the necessity of offering pregnant women the proper psychological care during an emergency in order to safeguard their mental health and reduce long-term effects on child development. 7. Low-income urban working women encounter numerous obstacles in their personal, professional, and environmental circumstances that could harm their mental health. Young women in India have a high frequency of mental health issues, but little study has been done to identify the factors that influence their mental health at home and at work. The association between job, family responsibilities, spouse support, stress management techniques, and mental health was investigated among 48 low-income working women living in urban slums throughout Bangalore, India, using a predominantly qualitative approach. Construction workers, domestic workers, factory workers, and street vendors selling fruits and vegetables were among the participants. Themes from qualitative data analysis included stress manifestations and effects, the state of mental health, factors that favourably or negatively impacted mental health, depression and stress mitigators. Even in

this small sample of females, there was evidence of severe sadness, including suicidal thoughts and suicide attempts. Women who are raising children with special needs, endure intimate partner abuse, have alcoholic or violent husbands, and don't have enough help for child care tend to be more prone to severe and protracted bouts of depression and suicide attempts. Social support from friends, family, and coworkers and job satisfaction were indicators of decreased anxiety and sadness. This qualitative study highlights the significant risk of depression among low-income working mothers in urban regions of India and reveals common stressors and stress-relieving behaviours in this demographic.

Chambers, Chiu et al conducted research on Factors Associated with Poor Mental Health Status among Homeless Women with and without Dependent Children. This study sought to examine if the presence of dependent children altered the effects of risk factors for poor mental health by estimating the prevalence of mental health issues among a representative sample of homeless mothers. In 2004–2005, homeless women (n=522) were enlisted from Toronto, Canada, shelters and food programmes. Regression analysis using linear and logistic models was used to find the elements that influence mental health. Low perceived social support, physical or sexual assault in the previous year, a chronic health condition, and drug use in the previous month were all linked to poor mental health. In order to promote mental health in this population, related issues must be addressed.

Women also go through a number of biological conditions because of which their mental health is affected. It is understood that biological and social changes might have an impact on a woman's mental health throughout menopause. With varying degrees of success, a number of research have looked into the connection between menopause and psychological disorders, particularly sadness. This is partly owing to difficulties in assessment brought on by a significant overlap between depressive symptoms and those caused by decreased oestrogen levels. However, it seems that weaker women are more likely to experience depression during the menopausal transition. Hormone replacement therapy has insufficient scientific support, thus antidepressants continue to be the go-to treatment for depressive symptoms. Menopause-related memory issues are a common complaint, although there is no evidence connecting them to later dementia.

Anxiety, depression, decreased sexual pleasure, a decline in health-related quality of life, and other mental health conditions have all been linked to polycystic ovarian syndrome (PCOS). Comparing the mental health of women with and without PCOS was done by a thorough review and meta-analysis of the existing research. Up till December 31, 2018, ten Chinese and English databases were searched. To identify the cause of study heterogeneity, random-effects models were incorporated, and subgroup analysis, sensitivity testing, and meta-regression were performed. According to the inclusion criteria, 46 studies with 30,989 participants (9260 women with PCOS and 25,638 controls) were eligible for review. There were 28 studies that examined depressive symptoms, 22 that examined anxiety, 16 that examined quality of life (QoL) status, 12 that examined sexual dysfunction, 5 that examined emotional distress, 4 that examined binge eating, and 4 that examined somatization. those with PCOS reported substantially greater levels of anxiety, lower quality of life, and not significantly higher levels of sexual dysfunction than those without PCOS. Results from studies conducted in various nations, using a variety of diagnostic tools, in various years, and with a variety of diagnosis criteria have revealed heterogeneous findings.

Marriage is a major life event for most people. This event brings a lot of changes in life.

A study was conducted inorder to evaluate married working women's mental health and correlates in Bhubaneswar, Odisha, India. A cross-sectional study using a multistage cluster random sample technique was conducted in 240 households with 240 married working women. All pertinent data was gathered using the self-reporting questionnaire and the predesigned, pretested interview schedule. Our study found that just 10% of the women who responded to the survey and had poor mental health had ever sought any form of mental health assistance.

According to the results of a logistic regression study, three predictors—a favourable attitude from coworkers, discussing personal issues with the husband, and scheduling time for yoga, meditation, and exercise—had a substantial positive impact on the mental health of married working women. In order to address this public health issue, a preventive programme involving many elements of mental health for married working women at the workplace as well as community level may be helpful.

Dudhatra and Jogsan conducted research on the mental health of working vs non-working women. The major goal of this study was to determine the mean differences in mental health and depression between working and unemployed women. Eighty women made up the entire sample. Dr. D.J. Bhatt and Gita R. Geeda (1992) measured the research tool for mental health. While Beck's (1961) depression treatment technique was being employed. The significance of mental health and depression in working and non-working women was examined in this study using the 't' test to test the correlation approach. According to the findings, there is a considerable difference between working and unemployed women in terms of their mental health and levels of depression. Non-working women have better mental health than working women, and less depression.

Aryal, Regmi et al conducted research on the Impact of Spousal Migration on the Mental Health of Nepali Women. Female migrant worker spouses who are left behind may experience mental health issues as a result of separation from their partners, a lack of companionship, and an increase in home duties. This study looked at the risk of mental illness in women who were left behind by foreign migrant workers in Nepal. A cross-sectional survey was conducted in the district of Nawalparasi. Although participants were picked at random, study regions were purposefully chosen. We employed the Beck Depression Inventory (BDI), the Connor-Davidson Resilience Scale (CD-RISC), and the 12-item General Health Questionnaire (GHQ) in Nepali.

According to GHQ, 3.1% of the participants were at risk for mental illness. 6.5% of participants had mild to moderate depression, according to the BDI, but no one had severe depression. In a bivariate study, frequent communication with the husband was linked to a lower risk of mental illness, less depression, and greater resilience. Low GHQ scores were also linked to reduced spouse return intervals and frequent remittances. Participants who spoke to their husbands at least once a day had a higher mean CD-RISC score (i.e., high resilience against mental ill-health risk) compared to those who did so at least once a week; a mean difference of 3.6 was found in a multiple regression model that controlled for potential confounding variables.

Marginalised sections of society do not have the same opportunities as everyone else, it has been proven that they are more prone to mental disorders due to their disadvantaged conditions.

Sex workers are a part of the marginalized section of society, most people are either forced into sex work or they enter voluntarily because of financial hardships. Whether sex work is at the street level or organised most of the research so far has focused on the physical aspects of it or sexually transmitted infections and HIV there is a need for research that explores the mental health of sex workers. A prospective, community-based cohort of on- and off-street women engaged in sex trade in Vancouver, Canada, is known as An Evaluation of Sex Workers Health Access (AESHA). Every two years, participants respond to surveys that are delivered by interviewers. Using bivariate and multivariate logistic regression, we examined the lifetime burden and correlates of self-reported mental health diagnoses. 338 (48.8%) of the 692 sex workers who were registered between January 2010 and February 2013 reported having ever had a mental health diagnosis, with depression (35.1%) and anxiety (19.9%) being the most frequent conditions. According to a multivariate study, women with mental health diagnoses were more likely to use non-injectable drugs, identify as LGBT, have experienced physical or sexual abuse as children, and work in unstructured indoor or outdoor environments. This analysis draws attention to the disproportionate mental health cost that women in the sex industry bear, especially among those who identify as members of sexual or gender minorities, who use drugs, and who operate in unofficial indoor venues and open-air areas. Along with regulations to promote access to safer workspaces and health services, evidence-based interventions specific to sex workers that address the linkages between trauma and mental health should be further investigated.

Laisuklang and Ali conducted a study on Indian Sex workers. Women who work in the sex industry experience more psychological discomfort. Female commercial sex workers (FCSWs) are linked to a number of psychosocial problems. A number of psychosocial factors, such as poverty, exposure to interpersonal violence as a kid, sexually transmitted illnesses, substance use, and childhood sexual abuse, provide a favourable environment for psychiatric morbidity. In Shillong, India, this study sought to evaluate the psychological morbidity among FCSWs.

A total of 100 FCSWs were chosen for the investigation. Simple random selection procedures were used to choose the sample, and sociodemographic questionnaires and the Mini International Neuropsychiatric Interview were given out. In the study, it was discovered that 21% of the respondents reported post-traumatic stress disorder (PTSD), 8% of the respondents reported alcohol dependence, 3% of the respondents reported non-alcohol psychoactive substance use disorder, and 8% of the respondents reported having a major depressive episode (current), major depressive episode (past), and major depressive episode with melancholic features (current). The FCSW has a high prevalence of mental health issues. In order to create health policies and interventions that have a smaller negative impact on the well-being of FCSW, it is important to assess the psychiatric morbidity of this population. The issue of the mental health status of commercial sex workers must be brought to the attention of governmental and non-governmental organisations, mental health specialists, and those who operate in this field immediately.

Eating disorders are debilitating conditions that affect every single aspect of a person's life. The mental conditions known as eating disorders—including anorexia nervosa, bulimia nervosa, binge eating disorder, and related syndromes—are incredibly unique. The peak age of onset is between 15 and 25 years old, or at a critical developmental stage. The typical sickness lasts for around 6 years. The majority of anorexic and bulimic patients are young women, although binge eating disorders are about equally prevalent in both sexes. In high-

income nations, eating disorder habits are becoming more common, particularly when obesity is present. Rising numbers of these presentations to health services reflect this growth. Furthermore, younger and younger people are being affected by the sickness. Anorexia nervosa is one of the most prevalent chronic illnesses in adolescence, at least as prevalent as type 1 diabetes, and affects one in six or seven young women. People with eating disorders and those who have anorexia nervosa have mortality rates that are about twice as high as the general population. Anorexia nervosa has a higher mortality risk in those aged 15 to 24 than other major adolescent illnesses like asthma or type 1 diabetes. People with bulimia nervosa or binge eating disorders are more likely to become obese or be obese, increasing their risk of obesity-related problems by one in every two to three. In Western society, adolescent females with eating disorders, particularly anorexia nervosa and bulimia nervosa, have traditionally been described. According to recent studies, they are also observed in developing nations like India. Recently identified ailments including binge eating disorder have been added to the list of eating disorders. The causes of eating problems are multifaceted. There is evidence that genetic factors are important. We now have a better knowledge of these disorders thanks to recent developments in neurobiology, which may someday lead to the development of more effective treatments. Premorbid personality appears to be significant, with varying propensities for specific diseases. It is debatable if cultural factors play a part in the aetiology of certain illnesses. Culture may have a pathoplastic effect that results in non-conforming manifestations like the anorexia nervosa form that is not fat-phobic, which is frequently observed in developing nations. The traditional forms of these illnesses are being reported all over the world as a result of fast cultural change. To account for these numerous manifestations, diagnostic criteria have been altered. Given the lack of well-established treatments and the lack of motivation or understanding present in eating disorders, treatment can be rather difficult. The primary forms of therapy continue to be nutritional rehabilitation and psychotherapy, however, medication occasionally proves beneficial.

The frequency of eating disorders is rising in Western nations, and research suggests that young women are most at risk of having these diseases. Programmes for prevention and intervention are crucial because of this. It is vital to pinpoint key risk factors that contribute to this condition in order to build these programmes. A non-clinical sample of 375 women was used to examine social risk factors for eating disorders (social comparisons, sociocultural attitudes towards beauty, and social anxiety). According to research, social comparisons are both directly and indirectly (through social anxiety) linked to a higher risk of developing eating disorders, but sociocultural views towards appearance are only indirectly (by social anxiety) related to a higher risk. A change in eating behaviour that results in altered food consumption and affects physical health and psychosocial functioning is known as an eating disorder (ED). The three most common disorders are binge eating disorder, bulimia nervosa, and anorexia nervosa. Worldwide prevalence rates of ED are rising, and they are particularly high in Western nations. For instance, the prevalence of anorexia and bulimia among young women is estimated to be 0.3% and 1.0%, respectively. Because of this, prevention and intervention programmes are crucial, but in order to design them, people who are at risk of developing ED must be accurately identified. According to some writers, millions of women may be affected by disordered eating if they are not appropriately treated, and there is research that suggests that young women from industrialised nations are more at risk of getting ED. Understanding that ED is multidetermined and that biological, familial, personality and sociocultural risk factors exist may help to strengthen these prevention and intervention programmes with this especially vulnerable group. Among the sociocultural influences, it's crucial to keep in mind the impact

of the media, societal perceptions of thinness, and social anxiety. The social standard of beauty and thinness that is portrayed in the media is one of the most significant elements associated with the development of ED. It is commonly known that there is a connection between ED and exposure to the usage of images in the media. These investigations into the connection between ED and exposure to idealised media pictures have highlighted the significance of this element in young women's propensity to acquire ED. These social comparisons that women make with those who are physically superior to them (such as models who feature in publications and on television) are linked to ED. The examined literature asserts that social comparisons between women and models and skinny girls in the media play an important role in the development of ED. As has been stated, the media's portrayal of beauty has a negative impact on women. However, the degree to which women support this thin ideal that permeates the media varies. The final authors claim that these sociocultural attitudes regarding appearance (awareness and acceptance of socially sanctioned criteria of thinness and beauty) may offer important insights for academics and medical professionals who are interested in ED. In actuality, this thin ideal internalisation is a significant ED risk factor that has evolved into the focal point of numerous preventative initiatives. The association between this variable (sociocultural views towards appearance), social comparisons, bulimia nervosa, and ED in general, has been established. Even a special tool for ED patients has been developed to measure sociocultural attitudes.

Social factors also play a role in the mental health of women.Abuse of females, including physical, sexual, and psychological/emotional abuse, is known as violence against women and girls (VAWG). The prevalence of emotional abuse against women and girls is generally low, if not usually ignored. In patriarchal countries, emotional abuse against women and girls is underreported in part because the abusers are stigmatised as repugnant (Boonzaier & De la Rey 2004). According to Ryan (1971), victim-blaming is the act of assigning guilt for an offence the former committed against the latter to the victim. There are numerous justifications for condemning women as victims. Women are frequently held accountable for anything that is convenient for the person criticising them, who is almost always a male (Taylor 2020). Taylor (2020) proposes that the main cause of their victimisation of women and underestimation of their abuse is ignorance. Female survivors, as well as their traits and behaviours, are held responsible and accountable.

Assigning blame for men's wrongdoings to women puts a tremendous emotional load on the latter, who already struggle with conformity to cultural and conventional norms and are frequently forced to do so. However, patriarchal societies indoctrinate people to focus on the defence of male offenders (i.e., by justifying or defending male offences) rather than on the male committing the offence(s) against women by framing women as the cause of and the solution to all male violence (Taylor 2020). Even in delicate situations where weak women are subjected to a barrage of abuse that is obviously having egregious effects on them to the point where they can become suicidal, victim-blaming women is unfortunately perpetuated and exacerbated by large segments of society and the media (Smith 2020). For instance, some groups justify the sexualized actions of men, even when they violate moral and legal bounds, such as debauchery, sexual harassment, and rape. Arguments that a man has an insatiable sexual hunger and that it is in his nature to be promiscuous have been advanced, sometimes vociferously (Taylor 2020). Such ingrained attitudes can significantly skewed perceptions of gender equality. The practise of placing blame on women, which is widely practised and normalised in gendered parental nurturing style (i.e., patriarchal upbringing), represents prejudiced traditions that are frequently based on hatred of women and girls and that manifest themselves in unequal and unfair treatment between genders (Taylor 2020).

Discrimination is a societal phenomenon when people are judged differently based on their gender, ethnicity, religion, sexual orientation, and race. In many regions of the world, gender discrimination against women is a problem in both the job and daily life. Gender discrimination manifests itself in many ways, including the gender pay gap, the difficulty of job and placing blame on women, which is widely practised and normalised in gendered parental nurturing style (i.e., patriarchal upbringing), represents prejudiced traditions that are frequently based on hatred of women and girls.

Women are also more likely to go through major life stressors like caregiving. Since governmental policy and population ageing place restrictions on the availability of professional care services, the majority of long-term care services for fragile older individuals are provided by informal carers. The first individuals in queue to offer informal care are older people's partners. Partners spend significantly more time providing care in numerous areas for a longer amount of time than other types of carers, and they receive less support from other informal carers. An unintentional change in a relationship that can lower its quality may result from a partner's ongoing and progressive impairment. Therefore, compared to other carer types, partners are more likely to get overworked. Future growth in the need for informal care could exacerbate this issue. Female carers bear a worse burden than male carers, according to research on carers. There are two possible schools of thought on the reasons why carer burden varies by gender. The first contends that because incentives, privileges, opportunities, and obligations are distributed unequitably between men and women in different structural situations, people are subjected to stressors of various types and intensities. Women may be forced to take on the position of carer more frequently than males due to the unequal distribution of chances and duties, which may hinder their performance in other areas (job, health). Women may have a heavier burden as carers since they devote more hours to caregiving and suffer more negative repercussions from it. The empirical test in this case uses a mediation model to demonstrate how much gender variations in conditions of burden can account for gender disparities in burden. According to the second line of argument, men and women have distinct experiences with caregiving in addition to having different load circumstances. It is believed that the conditions of load (such as the intensity of caregiving) may differ for women and men if women feel more responsible and obligated to provide care while men are more likely to stop providing care. A moderation model is used in the empirical test supporting this claim to determine whether the conditions have distinct effects on the burden for men and women. The purpose of this study is to advance understanding of the gender gap in caregiving.In 57% of the couples, the wife provided care, while in the remaining 43%, it was the husband. The average ages of the care receivers and the carers were both 77. On every level, female carers faced disadvantages. They reported more stress than male carers, had partners who needed more care, gave more hours of care per week, reported more secondary stressors, and got less aid from others. Only husbands utilised creche more than spouses. The latent variables' need factors and outside assistance did not differ significantly from one another.

DISCUSSION

At all phases of life, women are given certain schemas that they're expected to comply with. Right from the womb, females are treated in a different way than males. The birth of a male child is celebrated in the poorest of families and the birth of a female child is met with mixed emotions in a lot of families. Sex determination, a very common practice, and even a celebration in Western countries is banned in India due to increasing foeticide. Even as toddlers girls are treated differently than their male counterparts. Quality education and in some cases even quality food is reserved for the brothers and a clear pattern of

discrimination is established. Even young girls are expected to help out with household chores like cooking and cleaning but the same isn't expected from members of the family, this double standard sets an example for a behaviour cycle that will continue for the rest of their lives. Once they begin their schooling they are told one of two things. One is that there is no point in studying and that they should develop other skills that will help them become a better wife, and the other is that it is important to study so that they can match a good, educated husband. In both cases, marriage is made out to be the ultimate goal in a girl's life. Being capable, knowledgeable and independent in life are not things that they are taught to aim for. As a girl grows up and enters her teenage years, more and more rules, restrictions and ideals are set about what to do, how to act, and what to think. A lot of young women are married off immediately after graduation and they have no experience of independence financially or otherwise. They go straight from their parents' house to their husbands. For those who do work, finding a family that complies with their needs is difficult. And if they do find one there is almost always a struggle between home and professional responsibilities. Newly married couples are expected and pressured to have children immediately without proper planning. From then the same cycle is repeated again and again, for many generations. Women lack resources, both physical and mental to break this cycle. The social demands women face are just too many. All their lives women are taught to be selfless and think more about the wellbeing of others than themselves. As discussed above they are more susceptible to mental illnesses like anxiety and depression. Body image issues, eating disorders, sexual assault, domestic violence, prenatal depression, postpartum depression, workplace harassment, sexism, and discrimination are just a few of the issues they face. Women tend to repress their pain and are hesitant in asking for help for themselves. Women are also more likely to go through major life stressors like poverty or caregiver burden. Marginalised sections of the population like prostitutes or women of colour are often neglected but they are more likely to have mental health problems.

Women in South Asia are still denied their legal and socioeconomic rights in the new millennium. They exist in a society that is dominated by religious prohibitions, tribal regulations, feudal customs, and discriminatory legislation. The long years of childbearing are combined with a lifelong social and psychological disadvantage for you. They frequently experience mental incapacity, solitude, and poverty. Women's social positions have evolved somewhat in various urban areas of South Asian nations. They now have far greater options for employment, education, and the exercise of their civic rights in society. The traditional gender roles that have been ascribed by our culture are still far from being de-stereotyped.

Indian women have psychological issues that are comparable to those in the US but are considerably more pressing. India ranked 127 out of 152 countries in the UNDP's gender inequality index for 2014, according to the data. In a similar vein, India's performance in the World Economic Forum's Global Gender Gap Index-2014, which ranked 114 out of 142 countries, was dismal. The other indices are gender ratios and the genocide of women. In 2011, there were 65.46% more females than males who were literate, at 82.14%. However, literacy did not contribute to a decline in gender discrimination. Women in India have poor mental health as a result of being socially and economically marginalised.With a higher burden of older widows, the number of widows is significant and increased from 0.7% of the total population in 2001 to 4.6% in 2011. Remarriage is typically not authorised in upper castes; if it is, it may only be done with a family member, a widower, a divorcee, or a considerably older partner, mainly to help with the new partner's child-rearing (Trivedi, 2009). In addition to being subjected to social limitations on clothing, behaviour, diet, and mobility, people with low social standing may also face social ostracism (Mallick, 2008).

This, along with financial worries, might result in sadness and suicide (Chen, 2000). The symptoms of anxiety disorders and depressive episodes are made worse by limitations on activities that can be used to make money because of patriarchal standards. In 2014, 81 million physically abused widows and an estimated 115 million widows lived in poverty. The burden of loneliness and emotional uncertainty among women has increased due to an increase in widowhood, social constraints, and a greater sense of autonomy among the younger generation. Poor work-life balance and an increase in stress reactions have been caused by a sharp increase in the number of women who have not undergone any meaningful gender role transition. Working women experience emotional resentment and exhaustion as a result of patriarchy, misogyny, and a heavy workload at both work and home. A lot of people experience irritation, exhaustion, and other stress-related problems. Bhadury & Mukherjee (2015) draw the conclusion that women's "multi-tasking" is detrimental to their health based on the findings of their study. The worst thing is that the majority of affected women are between the ages of 32 and 58, and their ailments range from chronic back pain to diabetes, hypertension, high cholesterol, and heart and kidney disease to obesity, depression, and chronic back pain. Many women choose to stay in their current positions and decline advancements, not because they are shirkers but rather owing to the overwhelming demands of running a household and raising children.

Lack of safety, especially while travelling to work, lack of family support for household management, limited maternity leave, a severe workload, excessive expectations from the employer, and difficulties adjusting to work are just a few of the problems that women face. These are the main barriers that Indian women employees face when they want to advance their careers. males and women alike still have the perception that women are less capable than males. Because women in India are psychologically moulded to internalise the sense of their own inferiority, it has been observed that they contributed in the process of their own subjection. In her study, Varsha (2014) discovered that 53% of the females in the sample agreed that occasionally they felt hesitant to work with male coworkers and that 47% indicated they were uncomfortable with male coworkers. Almost 67% of women reported feeling uneasy because people made assumptions about their personalities. Indian women experience a variety of problems, including simple character assassination. The biggest worry is the passivity that has been inherited in women over the years, as well as their complete lack of life skills. Unexpectedly, the matriarch of the family is the one who orders the extermination of women in the name of a son. Many young ladies view covering the head as a symbol of dignity. The generation gap has grown as a result of mothers' bans on mixing boys and girls.The girls suffer from a lack of sharing and are not aware of how to deal with stalking and eve teasing. The current generation lacks the life and social skills necessary to deal with such problems. The unwavering embrace of the conventional role by the woman herself is a barrier to women's advancement.

Implications

The first step when it comes to anything that is mental health related is awareness. As discussed before, India is a developing nation and people have to work really hard to fulfil their basic needs, the standard of living isn't at a level that allows them to worry about their mental health and well-being. The government should take efforts to educate people about their mental health and how it is just as important as their physical health. A conscious effort should be made to reduce the stigma around mental health. Western countries have mental illnesses covered under insurance, in India, this act has been introduced very recently. This is also a part of the problem because this implies that mental illnesses are uncommon and not something normal that people seek treatment for. In addition to this, the government

should have subsidised mental health services just like any other services and make sure that quality psychological services reach even the remotest parts of the country.

When it comes to women in particular, the number one reason they stay in stressful situations is financial dependence.

Women should be empowered and educated so that they have the ability to leave situations that are not serving them well and affecting their mental health.

Other than this cultural and social factors play a very important role in creating the mindset the perpetuates the cycle of sexism. Efforts must be made to stop discrimination at grass root level and inculcate the right values in children from a young age. A Lot of people might argue that such systemic changes take time and do not happen overnight. This attitude needs to be changed because this kind of pluralistic ignorance is what has caused the problem in the first place. Each one of us needs to start implementing the changes we want to see in our own home and over time all of these small changes will cause systemic, large-scale change.

REFERENCES

Abi Rached, M., Hankir, A., & Zaman, R. (2021). Emotional abuse in women and girls mediated by patriarchal upbringing and its impact on sexism and mental health: a narrative review. Psychiatria Danubina, 33(suppl 11), 137-144.

Agarwal, N., Abdalla, S. M., & Cohen, G. H. (2022). Marital rape and its impact on the mental health of women in India: A systematic review. PLOS Global Public Health, 2(6), e0000601.

Ahmad, M., & Vismara, L. (2021). The psychological impact of COVID-19 pandemic on women's mental health during pregnancy: A rapid evidence review. International Journal of Environmental Research and Public Health, 18(13), 7112.

Almeida, M., Shrestha, A. D., Stojanac, D., & Miller, L. J. (2020). The impact of the Covid-19 pandemic on women's mental health. Archives of women's mental health, 23, 741-748.

Batool, F. (2020). Gender Discrimination at Workplace and Mental Health of Women: A Systematic Literature review. PalArch's Journal of Archaeology of Egypt/Egyptology , 17(8), 622-633.

Borrell, C., Artazcoz, L., Gil-González, D., Perez, K., Perez, G., Vives-Cases, C., & Rohlfs, I. (2011). Determinants of perceived sexism and their role on the association of sexism with mental health. Women & Health, 51(6), 583-603.

Carey, K. B., Norris, A. L., Durney, S. E., Shepardson, R. L., & Carey, M. P. (2018). Mental health consequences of sexual assault among first-year college women. Journal of American college health, 66(6), 480-486.

Ceulemans, M., Foulon, V., Ngo, E., Panchaud, A., Winterfeld, U., Pomar, L., ... & Nordeng, H. (2021). Mental health status of pregnant and breastfeeding women during the COVID-19 pandemic—A multinational cross-sectional study. Acta obstetricia et gynecologica Scandinavica, 100(7), 1219-1229.

Chandra, P. S., & Satyanarayana, V. A. (2010). Gender disadvantage and common mental disorders in women. International Review of Psychiatry, 22(5), 513-524.

Davenport, M. H., Meyer, S., Meah, V. L., Strynadka, M. C., & Khurana, R. (2020). Moms are not OK: COVID-19 and maternal mental health. Frontiers in global women's health, 1.

Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: A review of the literature. International journal of family medicine, 2013.

Dudhatra, R. R., & Jogsan, Y. A. (2012). Mental health and depression among working and non-working women. International Journal of Scientific and Research Publications, 2(8), 1-3.

Galvano, F., & Pugi, C. The dark side of Motherhood.

Garima, M., & Kiran, U. V. (2014). Impact of marital status on mental health of working women. Journal of medical science and clinical research, 2(10), 2594-2605.

Hosang, G. M., & Bhui, K. (2018). Gender discrimination, victimisation and women's mental health. The British Journal of Psychiatry, 213(6), 682-684.

Malhotra, S., & Shah, R. (2015). Women and mental health in India: An overview. Indian journal of psychiatry, 57(Suppl 2), S205.

MANKANI, R. M. R., & YENAGI, G. V. Y. G. V. (2013). Comparative study of mental health of working and non-working women. Karnataka Journal of Agricultural Sciences, 25(4).

Maqbool, M., Shrivastava, N., & Pandey, M. (2014). A comparative study of mental health of working women and housewives. Indian Journal of Health and wellbeing, 5(11), 1398-1400.

Nayak, M. B., Patel, V., Bond, J. C., & Greenfield, T. K. (2010). Partner alcohol use, violence and women's mental health: population-based survey in India. The British journal of psychiatry, 196(3), 192-199.

Niaz, U., & Hassan, S. (2006). Culture and mental health of women in South-East Asia. World Psychiatry, 5(2), 118.

Panigrahi, A., Padhy, A. P., & Panigrahi, M. (2014). Mental health status among married working women residing in Bhubaneswar City, India: a psychosocial survey. BioMed research international, 2014.

Platt, J., Prins, S., Bates, L., & Keyes, K. (2016). Unequal depression for equal work? How the wage gap explains gendered disparities in mood disorders. Social Science & Medicine, 149, 1-8.

Roberts, G. L., Lawrence, J. M., Williams, G. M., & Raphael, B. (1998). The impact of domestic violence on women's mental health. Australian and New Zealand journal of public health, 22(7), 796-801.

Rosenfield, S., & Mouzon, D. (2013). Gender and mental health. Handbook of the sociology of mental health, 277-296.

Sharma, I., & Pathak, A. (2015). Women mental health in India. Indian journal of psychiatry, 57(Suppl 2), S201.

Stewart, D. E., & Vigod, S. (2016). Postpartum depression. New England Journal of Medicine, 375(22), 2177-2186.

Swinkels, J., Tilburg, T. V., Verbakel, E., & Broese van Groenou, M. (2019). Explaining the gender gap in the caregiving burden of partner caregivers. The Journals of Gerontology: Series B, 74(2), 309-317.

Thibaut, F., & van Wijngaarden-Cremers, P. J. (2020). Women's mental health in the time of Covid-19 pandemic. Frontiers in global women's health, 1, 588372.

Travasso, S. M., Rajaraman, D., & Heymann, S. J. (2014). A qualitative study of factors affecting mental health amongst low-income working mothers in Bangalore, India. BMC women's health, 14(1), 1-11.

Yin, X., Ji, Y., Chan, C. L. W., & Chan, C. H. Y. (2021). The mental health of women with polycystic ovary syndrome: a systematic review and meta-analysis. Archives of women's mental health, 24, 11-27.

Acknowledgement
The authors appreciate all those who participated in the studies and helped to facilitate the research process, as well as all the authors of the articles reviewed for their contribution to the field. The authors also acknowledge each other's cooperation and efforts for this article.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Ghodke, J., Vora, N. & Gupta, A. (2023). Women's Mental Health: A Narrative Review. *International Journal of Indian Psychology*, *11(3),* 1258-1277. DIP:18.01.121.20231103, DOI:10.25215/1103.121