Integrating Gender in Medical Education

SUBJECT : PSYCHIATRY
COURSE : MBBS

A Guide for Medical Teachers

Cehat
Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai

MUHS
Maharashtra University of Health Sciences

Directorate of Medical Education and Research, Government of Maharashtra

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Preamble

The work done by CEHAT, the Directorate of Medical Education and Research, Government of Maharashtra (DMER) and Maharashtra University of Health Sciences (MUHS) to increase the knowledge and understanding of medical students about gender considerations (gender inequality, gender roles and behaviours, gender bias) as important social determinants of health and health care is to be commended.

This important effort directly responds to recommendations made at a 2006 meeting organized by WHO on *Integrating gender in the curricula for health professionals* that included to: Ensure that doctors and other health professionals are offered training with a gender-competent and human rights perspective; encourage and train health professionals to advocate for gender equality and health equity and to serve as agents for change; offer this training across all disciplines and along the learning continuum from undergraduate through continuing professional development; and work towards establishing accreditation standards on gender competencies within curricula.

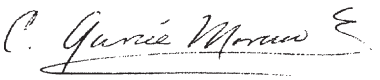
Medical education for long used the 70 kg male as the norm for determining, for example, dosages of drugs. It is only in the last few decades that awareness has grown about the fact that sex-based differences in women's bodies, related to size, distribution of fat, hormones and other characteristics, mean they may metabolize drugs differently and may at times require different dosages. It has taken time for medicine to pay attention to biological differences between women and men, beyond those related to the reproductive system, and to understand how these differences may manifest themselves in specific diseases or conditions, such as cardiovascular disease. Better understanding has developed also on how social constructions of femininity and masculinity (i.e., gender norms and behaviours) and the related unequal power relationships between women and men (i.e. gender inequality) are important risk factors and can impact negatively on health. Biological differences interact with gender inequality in ways that adversely affect the health of women and girls in many societies. Furthermore, gender interacts with other inequalities related to class, caste, ethnicity, migrant status that can exacerbate the negative health impacts. Gender biases may also affect the treatment and care they receive.

It is important that doctors have a clear understanding of how both biological differences and gender and other inequalities impact different aspects of health, how disease manifests itself, as well as the capacities of patients to protect themselves from disease. Doctors with this competency are more likely to provide appropriate and relevant care to their patients, be aware of the doctor-patient power differential and communicate

sensitively with patient of different ages, status and cultures. They are also more likely to identify and assist women and children affected by violence and abuse, an extreme manifestation of gender and other inequalities.

The content in these modules has been developed with attention to how to integrate gender-related content within existing topics and with minimal additional time requirements which make it more likely that this material will be used beyond this initial group of medical colleges.

A new generation of physicians with this knowledge and competency can lead to better medicine and better health care for all.



Claudia García-Moreno E *
World Health Organization

*This is not an endorsement of all the content in the modules. The views expressed are my own and do not necessarily represent the views or policy of the World Health Organization.

MUHS

महाराष्ट्र आरोग्य विज्ञान विद्यापीठ, नाशिक

MAHARASHTRA UNIVERSITY OF HEALTH SCIENCES, NASHIK

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Prof.Dr. Deelip G. Mhaisekar
M.D. (Pulmonary Medicine)
Vice-Chancellor

Foreword

I am pleased to inform you that Maharashtra University of Health Sciences (MUHS) has taken an important step towards "Gender mainstreaming" and "Gender sensitization" by suggesting gender-integrated modules in the existing MBBS curriculum. It is a known fact that recognition of social determinants of health can inform and make health services gender sensitive. It is with this objective that an innovative project on Integration of "Gender in Medical Education" was implemented under the aegis of Maharashtra University of Health Sciences (MUHS) by Directorate of Medical Education and Research (DMER), Centre for Enquiry into Health and Allied Themes (CEHAT) and was supported by UNFPA.

The gender-integrated curriculum was rigorously reviewed at different stages, as is the case with any new additions to the academic curriculum. The Authorities of the University has resolved to implement the gender integration modules with an intension that it would complement the existing MBBS teaching and these modules are available on the University website www.muhs.ac.in.

I am happy to announce that these modules may be implemented soon in the Medical curriculum. Medical educators in Maharashtra are being trained to use these modules. I am pleased to state that MUHS is the first university to implement the directions of NHP (2017) which speaks of the urgent need towards gender mainstreaming. Integration of Gender in medical education is definitely a step forward in that direction

Prof. Dr. Deelip G. Mhaisekar

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Preface

Integration of " Gender in Medical Education" (GME) has been a unique and challenging initiative of the Department of Medical Education (DMER), Maharashtra University of Health Science (MUHS) and Centre for Enquiry into Health and Allied Themes (CEHAT) supported by UNFPA. The Project was undertaken in seven medical colleges of Maharashtra with the aim to sensitise medical students and health professionals to gender inequity in health. As an outcome of the project a cadre of GME trained educators emerged, who enthusiastically participated in teaching gender integrated modules to the medical students.

An important contribution of this project has been the development of "Gender Integrated Modules" for the undergraduate medical curriculum for 5 disciplines namely-Obstetrics and Gynecology, Community Medicine, Internal Medicine, Forensic Medicine and Toxicology and Psychiatry. These modules have been specifically developed by trained medical educators in collaboration with CEHAT and experts in the field of gender equity and health. As this is the first such initiative in India, rigorous reviews of these modules were carried out by the board of studies and academic council of MUHS, Maharashtra.

The efficacy of these modules was tested by undertaking a research study in three of the seven medical colleges of Maharashtra. The study findings show a positive change in the overall gender attitude of medical students like a gender informed understanding of communicable and non communicable diseases, gender sensitive approach to the issues of violence against women (VAW), and sexual violence. Care had to be taken that the number of teaching hours are not increased. Hence, the focus was on using innovative teaching techniques such as case studies, role plays, games and quizzes to enhance learning and enable interactive sessions.

I would like to congratulate the medical educators and CEHAT for having undertaken such an important activity of developing gender integrated modules for five disciplines. I urge medical educators from different medical colleges of Maharashtra to use these modules with medical students so as to create gender sensitive doctors in the state of Maharashtra.

Dr. Pravin H. Shingare
Director Medical Education & Research,
Mumbai

From the Coordinator's desk

CEHAT has been working on the issue of women and health since its inception. It has been able to generate critical evidence on issues of access, discrimination and neglect of health equality in policy, programmes and practice. It has also been at the forefront in policy and legal advocacy on the issues of access to abortion services, gender insensitivity in healthcare response to VAW and sex selection/determination. The work also involved gender sensitisation of health providers and has been ongoing. A common issue that emerged was the need to impact the medical curriculum and make it gender sensitive so that doctors are sensitive to gender concerns when they enter the field.

The Integrating Gender in Medical Education (GME) initiative of CEHAT, DMER, MUHS and UNFPA was conceptualized after a lot of deliberation. Building on the earlier experiences in India and abroad, CEHAT decided to work closely with medical professors across 7 medical colleges in Maharashtra to train them as core faculty and bring about changes in medical curriculum in consultation with them. This was probably the best strategy as once the 19 professors completed the GME training; they were able to identify the gender gaps in their curriculum. The gender gaps were identified for every lecture of the UG MBBS curriculum as prescribed by the MUHS. Later, the CEHAT team along with the mentors and gender experts developed the gender content for each lecture. This was again reviewed by all the 19 trained faculty, mentors and gender experts.

The modules are supplementary efforts to existing MBBS curriculum and are structured with key messages for medical educators, and knowledge, skills and attitude changes expected in medical students. The section on content in the modules specifically provide examples of gender concerns related to health conditions and evidence snippet of steps by which gender can be integrated in a medical topic that is being taught by an educator. Each module has listed details of resources which can be read by the educator at their convenience. Case studies, debates, group discussions have been included as participatory exercises to assist medical educators in engaging students on gender and health.

Sangeeta Rege,
Coordinator, CEHAT

Acknowledgement

At the outset we acknowledge the contribution of several individuals and agencies in the preparation of these modules. We are grateful to Directorate of Medical Education and Research, Government of Maharashtra (DMER) and Maharashtra University of Health Sciences (MUHS) for guidance and encouragement received at all stages of the GME project, in particular Dr. Pravin Shingare who led the entire initiative. We also thank the Board of Studies and Academic council of MUHS (2016-2017) for supporting the Integration of Gender in Medical Education and approving the modules. We extend our heartfelt thanks to UNFPA for their funding support in carrying out this activity.

These modules have been developed jointly by the CEHAT team, the trained GME faculty, our mentors and gender experts. We thank each of them for their valuable feedback and suggestions on each draft. We would like to thank Dr. Shrinivas Gadappa and Dr. Priya Prabhu for guiding us at CEHAT through the project phase for administrative, strategic and intellectual inputs. They were always available and helped us navigate the system. We thank Dr. Hrishikesh Wadke for coming on board for developing the modules and helping in the pilot testing of the tools for the impact study. We are grateful to Anagha Pradhan for her extensive inputs in developing the modules for Community Medicine.

We also extend our sincere thanks to external reviewers for their critical feedback. We thank Dr. Manisha Gupte and Dr. Padmini Swaminathan for reviewing all the modules, Dr. Asha Oumachigi for Obstetrics and Gynaecology module, Dr. Rakhal Gaitonde for Community Medicine module, Dr. Rajendra Bangal for Medicine and Forensic Medicine and Toxicology module and Dr. Roopali Shivalkar for Psychiatry module. We thank Tejal Barai-Jaitly for critically reviewing the modules and helping in the finalisation of the content. We are grateful to Dr. Padma Prakash for language and content editing of the modules. We also thank Priyanka Shukla, Apurva Joshi and Vijay Sawant for helping us with referencing of the modules. We are grateful to Saramma Mathew for proof reading of all the modules.

We take this opportunity to thank our former colleagues from CEHAT who have contributed to the development of modules; we would like to thank Asilata Karandikar, Shreya Sen and Lakshmi Priya Menon who were involved in initial stage of module development. We would like to acknowledge Priya John and Ameerah Hasnain for their contribution in the content development for the Intervention modules related to the gender in medical education action research.

List of Contributors

The gender integrated modules have been a product of the joint efforts of 20 GME trained medical educators from seven medical colleges of Maharashtra in collaboration with CEHAT.

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Gender and Health Experts		TK Sundari Ravindran Renu Khanna

Table of Contents

Abbreviations

DSM - Diagnostic and Statistical Manual of Mental Disorders
DV - Domestic Violence
ECT - Electro-convulsive Therapy
GBV - Gender Based Violence
LGBTI - Lesbian, Gay, Bisexual, Transgender, Intersex
PHC - Primary Health Care
PSTD - Post Traumatic Stress Disorders
SV - Sexual Violence
VAW - Violence Against Women
SAQ - Short Answer Questions

Semester 4

1. Gender in psychiatry

♦♦♦

Gender content added : Gender and its association to mental health, need for gender analysis in psychiatric teaching and practice

Lecture name	:	Introduction to gender, gender based violence (GBV) in psychiatry practice (Additional Lecure)
Subject	:	Psychiatry main
Semester no	:	4
Duration	:	1 hour
Methodology	:	Lecture, Discussion and Role play
Resources	:	1. Malhotra, S., Shah, R. (2015). Women and mental Health in India: An overview. *Indian J Psychiatry,* 57(2), S205-S211. doi: 10.4103/0019-5545.161479 2. *WHO Fact sheet on Mental Health: Strenghtening our response.* Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/215275/RC63-Fact-sheet-MNH-Eng.pdf 3. World Health Organization, War Trauma Foundation and World Vision International. (2011). *Psychological first aid: Guide for field workers*. Geneva, Switzerland: WHO. Retrieved from http://www.who.int/mental_health/publications/guide_field_workers/en/
Handouts	:	---

Key Points

1. Understand that mental health and well-being is linked to the sex, gender, gender identity and sexuality (including sexual orientation) of a person.

2. Understand that gender is an important social determinant of mental health, and therefore should be integrated in provision of comprehensive mental health services and care.

3. Recognise violence against women (VAW) / gender based violence (GBV), and its link to mental health and health care.

Learning Outcomes

Knowledge	Skill	Attitude
Student should be able to understand how gender affects mental health	Student should develop competence in associating gender with specific mental health concerns and provide gender sensitive health services	Student should be able to recognize that gender expectations, as well as gender identity and sexuality of a person affects their mental health

Note for Educator: *Explain the importance of gender as an important determinant of mental health*

Content

Sex: Biological difference between males and females. However, some people are born intersex, and some individuals may not conform to the sex assigned to them at birth.

Gender: Gender refers to social, economic and cultural attributes expectations, roles and opportunities associated with being male or female in a particular setting at a particular point in time. Closely linked to this is the concept of gender identity. Gender identity, is not determined by chromosomal or anatomical sex of a person. It is the personal conception of how an individual identifies herself / himself; it is the individual's preferred gender expression, role and presentation, as male, female, both or neither.

Intersex: Non-conformity of an individual's body to prevalent ideas of maleness and femaleness. It is used as a term for different biological possibilities and variations, which may include, for instance, a large clitoris, absence of vagina, and congenital absence of gonads among others.

Transgender: Individuals whose lived gender identity does not conform to their physiological appearance. It includes cultural categories such as *'hijras'*, transvestites as well as transitioning or post-operative trans persons. Transgender people may identify with either male or female gender identity, both, or neither.

Sexual orientation / identity: Human sexuality is diverse and multi dimensional, encompassing sexual identities such as asexual,[1] heterosexual,[2] homosexual,[3] bisexual,[4] pansexual[5] and so on. Sexual orientation may change over a person's lifetime.

Heteronormativity: The belief that heterosexuality (being attracted to the 'opposite sex') is the only 'normal' sexual attraction. The fact that heterosexuality has been historically promoted as the only acceptable sexuality has led to social bias and stigmatisation of people belonging to non-heterosexual preferences and communities. These biases have also found their way into medical and psychiatric textbooks.[6] Health professionals are also a part of the social milieu, thereby reflecting biased attitudes against non-heterosexual people. Such attitudes can discourage people from seeking health services in general and mental health services in particular.

I. Gender and Psychiatric services:

In case of women, the exclusive focus of psychiatry has been on mental health implications for women in reproductive health. Contraceptives, fertility, pregnancy, breast feeding, medical termination of pregnancy and postpartum depression are discussed in psychiatry but with a focus on the biology and its effects on mental health. Psycho-social aspects that determine these conditions have hardly received much attention. Arriving at a psychiatric diagnosis is seen as intrinsic to the patient rather than her reaction or response to the socio-cultural factors and gender role she plays. These result in labeling the woman patient without fully understanding her subjective experience. Such labeling inadvertently perpetuates her secondary status in society.

Psychiatry can challenge the notions of womens mental health concerns being psychosomatic. Often society at large and even health providers trivialize womens distress. This is seen in situations where women suffer seizures, attempt suicide or display frustration. Loose comments are often passed as women being attention seeking or engaging in 'hysterical behaviour'. It must be remembered that the medical construction of women's bodies is imperfect and that the term hysteria has its origin in ancient Greek medicine wherein the 'wandering uterus' (hysterik) caused unexplained and irrational

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[1] Individuals who feel little or no sexual attraction
[2] Men who are attracted to women, women who are attracted to men
[3] Individuals attracted to people of the same sex
[4] Individuals attracted to men and women
[5] Individuals attracted to other individuals regardless of gender, i.e., man, woman, transgender
[6] Davar, B. (2005). Teaching Psychiatry with a Gender Perspective. *Economic and Political Weekly,* 40(18), 1882-1886. Retrieved from http://www.epw.in/system/files/pdf/2005_40/18/Teaching_Psychiatry_with_a_Gender_Perspective.pdf

behaviour among women. Unless these notions are challenged, psychiatric practice is likely to do harm, even if inadvertently. Psychiatric doctors can play an important role in challenging such stereotypes about women.

WHO in International classification of diseases (ICD 10) removed homosexuality as a mental disorder only in 1992. Until then psychiatric practice considered homosexuality as a disorder. Even now the term "ego dystonic sexual orientation" in the ICD is associated with behavioural disorders. But very little evidence exists on mental health consequences of marginalised communities such as women, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex (LGBTQI) and homosexual people. There is a dearth of Indian literature on psychological consequences and nature of mental health services required by homosexual individuals.[7] The American Psychiatry Association issued a statement proscribing "Conversion therapy" stating that its harmful to individuals. Despite that the practice of conversion therapy has not been discontinued in India[8].

National mental health policy 2014.[9] places importance on recognising the need for mental health services to cater to diverse social and cultural situations and to the needs of different people including those living in remote places. The policy stresses upon the need for evidence based mental health services which comprises of research, direct work at the level of services and voices of users of mental health services. The policy underscores that mental health services are aimed at creating services that uphold the dignity of persons as well as their autonomy and hence stress upon rights of persons with psycho social / intellectual disabilities as well as mental illnesses. Vulnerability has also been clearly defined in the policy such as homelessness, poverty, internal displacement of people, those living in situations of conflict, sexual minorities amongst others. It urges governments to make efforts towards creating universal access to mental health services. The national mental health policy has already been notified and India has also recently revised mental health care law. The Mental health legislation has enshrined the language of rights of people with mental illness as well as psycho social disabilities. Hence it is important to establish protocols for implementing these direction.

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[7] Rao TS Sathyanarayana, Jacob, KS. (2012) Homosexuality and India. *Indian Journal of Psychiatry,* 54(1), 1-3. Retrieved from http://www.indianjpsychiatry.org/article.asp?issn=00195545;year=2012;volume=54;issue=1;spage=1;epage=3;aulast=Sathyanarayana

[8] Patra, Suravi (2016) Conversion therapy for homosexuality: serious violation of ethics. *Indian Journal of Medical Ethics,* 1(3), 194-195. doi: 10.20529/IJME.2016.056

[9] Ministry of Health and family welfare, Government of India. (2014) *New Policy New Hope : National Mental Health Policy*. New Delhi, India: MoHFW. Retrieved from https://www.nhp.gov.in/sites/default/files/pdf/national%20mental%20health%20policy%20of%20india%202014.pdf

Currently psychiatric services are not integrated at the level of primary health care (PHC) services. Evidence shows that women are more likely to visit PHCs than tertiary care services to seek care and therefore urgent steps need to be taken to integrate mental health services at the primary and secondary levels of health care if the policy has to be implemented in its spirit.

II. Women, violence and mental health

It is pertinent to examine the role of violence against women and its effect on their mental health. Gender socialisation expects passivity and submission from women. If we examine women's work status, they are paid lower than their male counterparts, and are hired more for casual and part time work, leading to job insecurity. They are also subjected to the triple burden of productive (employment), reproductive (bearing children) and caring work (upkeep of the family and managing domestic responsibilities including care of children, the sick, and elderly family members) These strenuous experiences and expectations can lead to increased mental stress.

VAW, whether physical, psychological, economic or sexual, increases women's risk to mental ill health. High incidence of sexual violence (SV) against women and girls has resulted in them being the largest group to suffer from Post Traumatic Stress Disorders (PTSD). Another leading consequence of living with violence has been the high incidence of attempted suicide. Several studies conducted in high income countries have shown a higher lifetime risk of suicidal behaviour among women facing domestic violence (DV).[10,11,12,13,14,15,16] These studies have assessed this relationship in a fairly diverse sample of women, including female physicians,

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[10] Kaslow, N. J., Thompson, M., Meadows, L., Jacobs, D., Chance, S., Gibb, B., et al. (1998). Factors that mediate and moderate the link between partner abuse and suicidal behaviour in African American women. *Journal of Consulting and Clinical Psychology,* 66, 533-540.

[11] Vizcarra, B., Hassan, F., Hunter, W. M., Muñoz, S. R., Ramiro, L., De Paula, C. S. (2004). Partner violence as a risk factor for mental health among women from communities in the Philippines, Egypt, Chile, and India. *Injury Control and Safety Promotion,* 11(2), 125-129.

[12] McFarlane, J., Malecha, A., Gist, J., Watson, K., Batten, E., Hall, I., Smith, S. (2005). Intimate partner sexual assault against women and associated victim substance use, suicidality, and risk factors for femicide. *Issues in Mental Health Nursing,* 26(9), 953-967.

[13] Sato-DiLorenzo, A., & Sharps, P. W. (2007). Dangerous intimate partner relationships and women's mental health and health behaviours. *Issues in Mental Health Nursing,* 28(8), 837-848.

[14] Wong, S. P., & Phillips, M. R. (2009). Nonfatal suicidal behaviour among Chinese women who have been physically abused by their male intimate partners. *Suicide and life-threatening behaviour,* 39(6), 648-658.

[15] Dufort, M., Stenbacka, M., & Gumpert, C. H. (2014). Physical domestic violence exposure is highly associated with suicidal attempts in both women and men. Results from the national public health survey in Sweden. *The European Journal of Public Health,* 25(3), 413-418.

[16] Dufort, M., Stenbacka, M., Gumpert, C. H. (2014). Physical domestic violence exposure is highly associated with suicidal attempts in both women and men. Results from the national public health survey in Sweden. *The European Journal of Public Health,* 25(3), 413-418. doi:10.1093/eurpub/cku198

community dwellers, wives of alcoholics and psychiatric patients. Some of these longitudinal studies have also attempted to assess the temporality of the relationship between domestic violence and suicidal behavior.[17,18]

Despite this well-documented evidence and the attribution of attempted suicide to women's experience of domestic violence, psychiatrists tend to psychologize women's reactions to stressful situations, including experiences of abuse. Deliberate self harm and 'false alarm' are terms often used to describe failed attempts to suicide. It is important to recognise that women may not have access to lethal weapons the way men do. Hence, women attempt suicides by way of what is readily available in their homes such as insecticides, pesticides or overdose of a medication. It is critical to look for underlying reasons related to suicide attempts, and also probe for possible DV or sexual abuse.

Trans women and people with diverse sexual orientation are also at a higher risk of suicide because of the daily experiences of discrimination, rejection, hate, stigma and invisibility they face, as well as the multiple forms of violence they encounter inside and outside the home. When a suicide attempt fails, and women or transgender people are referred to a psychiatrist for an assessment it is important to acknowledge the intent to suicide and not trivialise or dismiss these just because they have been 'non fatal' attempts.

Few examples of gender insensitive psychiatric treatment include[19] :

- Inhuman, cruel and degrading treatments, including solitary confinement and direct shock treatment.

- Not protecting confidentiality and not obtaining informed consent for treatment from the woman.

- Use of 'aversion therapy' particularly in the name of 'curing' homosexuality, indiscriminate use of electro - convulsive therapy (ECT).

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[17] Ehrensaft, M. K., Moffitt, T. E., Caspi, A. (2006). Is domestic violence followed by an increased risk of psychiatric disorders among women but not among men? A longitudinal cohort study. *American Journal of Psychiatry,* 163(5), 885-892.

[18] Devries, K. M., Mak, J. Y., Garcia-Moreno, C., Petzold, M., Child, J. C., Falder, G.... Pallitto, C. (2013). The global prevalence of intimate partner violence against women. *Science,* 340(6140), 1527-1528.

[19] People's Health Movement-India. (2007, March 8). *Indian Women's Health Charter* [PDF]. Retrieved from http://phmindia.org/wp-content/uploads/2015/09/Indian_Womens_Health_Charter.pdf

- Unauthorised or non - consensual experimentation on women suffering from psychiatric disorders, physical and emotional cruelty and torture of these women.

- Not recognising a person prone to mental illness as a 'person' before the law, not respecting her capacity to act on the basis of her will and preferences.

- Coercive use of contraception, conducting coercive tubectomy or hysterectomy operations on girls and women who are under institutional or non - institutional custody and care.

Role of Doctor

At the level of the Psychiatry department, there should be:

- A protocol / standard operating procedure that is gender sensitive .

- Training on how to ask questions with sensitivity to elicit response and probe beyond what has been shared.

- Private setting, away from family and crowd in the clinic.

- Confidentiality ensured.

- Non judgmental behaviour of professionals and reassuring mannerism.

- System for referral in place.

Activity

- Students are divided in to two groups. Each group is given a case study

- Students are asked to identify if gender has a role to play in the patient's current health complaint.

- One person from the group presents the discussion.

Case Study 1 [20] *:*

Sneha is an articulate and self-reflective twenty-three year old woman, presently employed in a large multi-national company. Sneha was referred for feelings of depression and inability to concentrate on her work. During the first session itself, her negative self-cognitions were seen, including self-blame, guilt, and bruised self-esteem. It turned out that she had been in a relationship since the past four years with Nitin, who had been her classmate in school. She described him as "protective, very concerned about her welfare and her decisions" and though living in different cities now since the past one year owing to their jobs, she said he was constantly involved in all aspects of her life-ranging from decisions related to her career moves, to whom she should meet and interact at work, and to what her appropriate attire should be on various occasions.

A few months ago, when she was selected by her organisation for an assignment abroad, he flew down to supervise her travel preparations and her itinerary, despite all such arrangements being made by her company. His last-minute instructions comprised the exact timings of phone calls she should make to him when she was abroad. Once, when they were living in the same city, he had walked in into her office, unannounced, and when he found that she was not wearing the dress that he had instructed, went into a rage, and slapped her there itself.

She said this was the only incident of physical violence, and since he had immediately apologised and was more careful thereafter for a few days, she decided not to take the issue seriously. On his first visit to her new office in a different city, his immediate reaction was reportedly dismay at the sight of so many young male colleagues. He left after giving her a series of instructions about how she should behave with them at the workplace, including advice on refraining from social interactions with them beyond work. All this was supposedly because "she did not know how men were"!

[20] Case study stated by Vindya U at Course conducted 'National course on responding to violence against women through feminist counselling from 25th Nov 2011' by CEHAT

Once she had inadvertently left her apartment door unlocked, and though nothing untoward had happened, not only did he repeatedly advise her to put on a self-closing lock and so on, but also used this incident to prove his point that she was not yet capable of looking after herself. Even at her work, she was advised not to take up particular promotions because he felt she was still 'immature' and not capable of discharging responsibilities required in handling such jobs. Her decision to move to another city was met with stiff opposition. Although she had managed to convince him somehow then, she now found that this long-distance relationship turned out to be in fact worse, since he started checking on her whenever he felt like. She said she was now living in constant dread of his unexpected visits or frequent phone calls and forever wondering whether she would be 'caught' for doing 'something wrong'. She further pointed out that he did not have any problems in his work place, was showing promising signs of upward mobility in his own career, had a wide circle of friends, and was in general, "cheerful, witty, and smart" - qualities that she had initially found endearing. Furthermore, because of his appealing qualities otherwise, Sneha attributed the difficulties in their relationship to her own 'immaturity and deficiencies'. As she put it, "It is because I am not too good at taking sensible decisions, and not practical and worldly wise that he chooses to guide me, and tell me what I should do and how I should behave with others". As she narrated more details of her relationship, she specifically wanted to know whether the behaviour of her boyfriend could be categorised as 'abusive behaviour'.

Questions for Discussion

1. Would you describe Sneha's boyfriend's behaviour as abusive?

2. If so, why and how? If not, why not?

3. How will you respond to Sneha's question?

4. What would be the components of gender sensitive mental health care in Sneha's situation?

Discussion can be carried out in the class room about the 'over protective, abusive behaviour' of Nitin and what advice needs to be given to him.

Case Study 2:

Seema is a 24 year old woman, married for a year. She has studied up to the 10th standard and works in a private company earning Rs.2000/- a month. She is two months pregnant. Her parents brought her to the hospital, as she reported accidental consumption of phenyl. As a part of the hospital procedure, Seema is referred to the psychiatry department.

Seema narrates that she had an arranged marriage that was fixed by common relatives. Her husband constantly pressurises her to have sex. She feels that he does not understand her emotionally. In that fit of frustration, she had consumed the phenyl. Her husband did not bring her to the hospital, he merely informed her parents, and they brought her to the hospital.

Seema shares that her husband wants her to give up everything she earns to him. He does not even understand when she is unwell. She has been advised by her close family members that complying with her husband's demand is the best way of dealing with the situation. She reports feeling confused about the next steps she should take and expresses anxiety.

Questions for Discussion

- How would you as her psychiatrist deal with the situation?
- What would you call her current mental health condition? Will you diagnose her? If yes what would the diagnosis be? Would a 'diagnosis' end your responsibility towards Seema?
- If you do not diagnose? What would be the reason for it? What would you do instead?

A health care provider should keep following points in mind while interviewing the patient

- Should ensure that consultation is conducted in private, allowing woman the scope to discuss her underlying conditions, which could help provide a differential diagnosis.

- Should ensure confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting).

- Should be non-judgmental and supportive and validate what the woman is saying.

- Should provide basic crisis intervention support comprising of a safety plan for herself and her children, if involved and practical care and support.

- Should identify support from those who care for the woman including sensitive family members, friends or women's organisations.

CHECKLIST TO ENSURE GENDER-SENSITIVE APPROACH IN PSYCHIATRY DEPARTMENT[21]

Items	Yes	No	NA
Procedures in place to ensure privacy			
• Having an enclosed space to talk to the patient			
• Ensure that you speak with the patient alone, apart from speaking in the presence of relatives or accompanying persons			
Information obtained from patients treated in a confidential manner • Ensure that information given by the patient remains confidential in any form, verbal, written, recorded or computer-stored, and is not revealed to any person without the patients' consent; instances of breach in confidentiality while transferring the information between two different devices will be taken care of			
• Making patients aware of reasons for which the information given by them needs to be communicated to any other person: a) Other doctors b) Carers and families c) Police / lawyers			

[21] The following checklist was developed by the mentors and GME faculty under the Integrating Gender in Medical Education project in Maharashtra. It was felt that this must be taught to students before they are placed for their clinical postings. The checklist was reviewed by 37 medical educators across Maharashtra in a Workshop on Evolving Evidence based Clinical Practice held on 24th - 25th November, 2017 in Mumbai. This was organized by CEHAT in collaboration with the DMER, UNFPA, Seth GS Medical College and K.E.M.Hospital.

Items	Yes	No	NA
Information pertaining to HIV + status, incidence of domestic violence or sexual abuse and also of suicidal thoughts and / or previous suicide attempts may need disclosure to intimate persons in the family. This disclosure should be done in a sensitive manner.			
Counselling skills specific to gender issues e.g. building rapport and trust, being non-judgmental, respectful • Use open-ended, non-intrusive questions to build rapport • Not make assumptions about patient's mental health based on their cultural context, sexual orientation, gender identity, etc • Use of body language that is open and non-confrontational			
Responding appropriately to sharing of extremely private information e.g. abuse, rape • Acknowledgement of patients' disclosure in a sensitive manner and showing trust towards his / her disclosure • Ensuring that patient's past sexual history does not bias response and treatment • Reassure patient that confidentiality about disclosure of sexual orientation and gender identity will be maintained • Past history of mental illnesses in the family			
Details of sexual and reproductive health i.e. menstrual history, childbirth / pregnancy, obtained in sensitive manner • Making a distinction between past sexual history and past sexual abuse • Maintaining a non-judgmental attitude towards disclosures about abortion • Maintaining confidentiality and non-judgmental attitude towards disclosure about sexual orientation and gender identity			

Items	Yes	No	NA
Social difficulties and stressors explored in detail • Bearing in mind that marginalizing factors such as sexual orientation, gender identity, class and caste location, disability of any form could add to patient's vulnerability and affect their coping mechanisms • Recognizing support systems and strategizing treatment accordingly			
Physical / somatic symptoms and their relationship to depression addressed • Not being dismissive of patient's complaints of physical symptoms			
Specific information about domestic violence, abuse, rape obtained in sensitive manner			
Self harm / suicide risk assessment done thoroughly and appropriate management instituted • Recognizing that deliberate self-harm can put the patient at risk for attempting suicide or repeated self harm and not dismiss it as merely "attention-seeking" behaviour. • Enquire sensitively about past attempts at self-harm or suicide; explore the reasons behind the attempts and respond in a non-judgmental manner			
Patient and family helped to make decisions around education, employment, marriage if relevant (especially for patients with psychosis, epilepsy)			
Physical examination done in a manner that respects patient's privacy and dignity			

Items	Yes	No	NA
Involvement of a family member whenever possible after obtaining patient's consent (especially in cases of domestic violence, interpersonal conflict).			
Patient interviewed privately (without the family member) to obtain sensitive information			
Diagnosis provided in a sensitive manner without stigmatising labelling of a person such as 'attention seeking', 'hysterical' psychotic etc.			
Psychotropic medication and indirect ECTs prescribed judiciously in line with current guidelines			
Caregiver burden addressed and strategies to reduce this are discussed • Addressing concerns of violence perpetrated by patient on carer or other family member			

Short Answer Questions (SAQ)

Questions:-

1. Explain the mental health consequences of women and girls facing violence

2. Explain gender identity and its relation to mental health

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