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PROMOTING PSYCHOSOCIAL SUPPORT FOR WOMEN LIVING WITH MENTAL ILLNESS IN ZIMBABWE: THE ROLE OF SOCIAL WORK

Chipo Chitereka and Stella Takaza
Lecturer, Department of Social Work University of Zimbabwe, Zimbabwe

ABSTRACT

Mental disorders are increasingly affecting people worldwide and access to health care services alone without psychosocial support cannot provide a holistic treatment to women living with mental illness. Women in Zimbabwe encounter a plethora of biopsychosocial problems, including having genetic dispositions to mental illness, stressful events, difficulty family backgrounds, poverty, domestic violence, intimate partner violence, physical mental problem, among others that result in causing mental health problems.Whilst they can access medical care from health care institutions, deprivation of psychosocial support hinders the provision of holistic therapy to women living with mental illness for them to be fully functional members in their communities. Lack of adequate availability of psychosocial support for women living with mental illness affects their self-esteem as they cannot engage in activities that restore their social functioning. Inadequate psychosocial wellbeing for women living with mental illness inhibits their ability to deploy available resources effectively in shaping their own world in response to the challenges they encounter. This article argues that the promotion of psychosocial support can be enhanced through social work interventions. Social workers play a major role in mental health settings and communities as they seek to empower individuals with mental health problems to lead fulfilling independent lives.

Key words: mental disorder, mental health, mental illness, psychosocial support, social work, women, holistic.

Introduction

Mental health is a phenomenon that account for a significant burden of disease in all societies. World Health Organisation, (WHO) (2011) estimated that around 450 million people suffer from a mental or behavioural disorder which account for 12% of the total global burden of disease. Mental disorders are associated with a considerable burden of morbidity and disability and they cause a great deal of suffering to those who are experiencing them as well as to their families and friends (WHO, 2013). Developing countries including Zimbabwe are the most affected and are likely to have disproportionately large increase in the burden attributable to mental disorders in the coming decades (WHO, 2003; HealthNet TPO, 2011).

In Zimbabwe mental illness is a serious medical condition with significant public health impact as it is surrounded by stigma and discrimination connected to religious and cultural beliefs. The traditional belief is that mental problems are caused by external phenomena such as displeased ancestral spirits or witchcraft. Despite relating the causes of mental disorders to traditional beliefs, people are bound to continue seeking mental health care from health care centres throughout the country. However, medical health care alone is not sufficient in providing a holistic treatment to women living with mental disorders.Promoting psychosocial support for them is requisite as it complements the medical care provided by health care institutions. Psychosocial support aims at assisting people to restore normal life and empower affected people (Stavropoulou & Samuels, 2015). As an approach to support women living with mental disorders, psychosocial support enables them to cope with the problematic situations they encounter, thereby fostering resilience of communities and individuals (Macleod & Smith, 2003; Stavropoulou & Samuels, 2015). Social workers are change agents who can work productively with women living with mental illness through engaging them in developmental activities in promoting their psychosocial wellbeing.

Objectives

This article seeks to examine the concept of mental health and mental illness as well as the causes of mental illness. The article will also explore the role of social work in promoting psychosocial support in enhancing the social functioning of women living with mental disorders.

Methodology

This article is unequivocally qualitative in nature. The researchers carried out desk reviews based on data collected from books, journal articles and web-news. Information on mental health and mental illness among women, mental health care in Zimbabwe, as well as how social workers enhance psychosocial wellbeing of women living with mental illness was synthesised in alignment with the research objectives.

Understanding mental health and mental illness

Mental disorders are among the top five causes of disease burden in Africa and are associated with disability and social isolation (Ministry of Health and Child Care, 2016) but they are not consistently recognised as a public problem (Bird et al. 2011; Pitoraki et al. 2013). However, they cause considerable suffering, disability and social exclusion in Africa since they are

poorly recognised and rarely treated (Monteiro, 2015). Mental disorders are of different types and degrees of severity. Some of the major types are depression, anxiety, schizophrenia, bipolar mood disorder, personality disorder and eating disorders. A comparative analysis of empirical studies revealed a consistency across diverse societies and social contexts that symptoms of depression and anxiety as well as unspecified psychiatric disorder and psychological distress are more prevalent among women whereas substance disorders are more prevalent among men (Young, n. d). The most common mental illnesses that are prevalent among women in Zimbabwe are anxiety and depression (Chibanda et al. 2011). Hence mental disorders affect women and men differently.

Quite often mental health is envisaged as mental health problems and mental illness, but this is one part of the picture since everyone has 'mental health' and this can be thought of in terms of how people feel about themselves and other people around them; the ability to make and keep friends and relationships; and the ability to learn from others and to develop emotionally. As well, being mentally health is about having the strength to overcome the difficulties and challenges that a person faces in a life cycle, having confidence and self-esteem, in order to be able to take decisions and to believe in one's capability. Though mental health and mental illness can be perceived as two distinct issues, they are interrelated.

According to WHO (2012) mental health or psychological wellbeing makes up an integral part of an individual's capacity to lead a fulfilling life, including the ability to form and maintain a relationships, to pursue leisure interests as well as making day to day decision. As defined by WHO (2004)mental health is a state of wellbeing in which every individual realizes his/her potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his/her community. As well, John Stone (2001) defines mental health as the capacity of individuals and groups to interact with one another and the environment in ways that promote subjective wellbeing, optimal development, and the use of cognitive, affective and relational abilities. Due to the fact that a cross-cultural definition of mental health is impossible it is originally agreed that mental health is not equated with absence of mental disorder but it includes subjective wellbeing, self-efficiency, autonomy, competence and realisation of one's potential (Stavropoulou & Samuels, 2015)

While every person experiences strong feelings of tension fear and sadness at times, a mental disorder is present when these feelings become so disturbing and overwhelming that an

individual will have great difficulty coping with day to day activities such as work, enjoying leisure time and maintaining relationships (Australian Government's HeathInsite, n. d). Mental illness is a developmental brain disorder with genetic and environmental factors leading to the altered circuits and altered behaviour and it ranges from autism to schizophrenia (Missouri Department of Mental Health, 2011).These disturbances to an individual's wellbeing can adversely compromise the capacity to make choices leading to diminished functioning at individual, household and societal level. Hence, mental illness is a brain dysfunction or health problem that significantly affects how a person feels, thinks, behaves and interacts with other people.

Mental illness is surrounded by a plethoraof myths, misunderstandings and negative stereotypes and attitudes. People living with mental illness are among the most devalued of all people with disabilities and have to endure hearing hurtful comments, being treated as less competent, being told to lower their expectations in life and being shunned or avoided (Canadian Mental Health Association, 2002). This is exacerbated by people's beliefs and attitudes toward mental illness which fosters avoidance, exclusion from daily activities and in the worst case exploitation and discrimination (Gajendragad, 2015;Huggett, 2018). Research has demonstrated that discriminatory attitudes and behaviour toward people with mental illness and their families have enormous and far reaching consequences and impacts that force them to cope with two simultaneous burdens: a debilitating condition and societal reactions to that illness that deny them respect and dignity (Canadian Mental Health Association, 2002). Internalisation of what society says about them leads to lowered self-esteem, reduced quality of life and negative effects on health. In addition, the cluster of negative beliefs and attitudes that motivate the general public to fear, reject, avoid and discriminate against mental illness results in stigmatization (Department of Health and Human Services, USA, 2012).

Though people with mental health problems try to cope with their primary condition they also experience the secondary impact of mental health stigma (Huggett, 2018).Given that people suffering from mental illness are the most stigmatised in society, this may lead to social exclusion which results in unequal access to resources that all people need to function well such as educational opportunities, employment, and supportive community including friends and family as well as access to quality health care (Thornicroft et al. 2007; Gajendragad, 2015). The stigmatization of people with mental disorders creates in them embarrassment in

accessing mental health services since they will be hiding the symptoms and may also interfere with self-management of mental disorders. Women may be less likely to seek treatment after experiencing symptoms of mental illness due to internalised or self-stigma that results from their self-image being formed by how others perceive them (Gajendragad, 2015).Thornicroft et al (2007) contended that women are more prone than men to feel stigmatised for seeking assistance in relation to mental issues because they tend to rely on opinions of the outside world for their self-esteem more than men do. Lack of treatment may have grave consequences for people living with mental illness and negatively impact on families of people affected by these disorders.

Bio psychosocial Model of Disease

The causes of mental illness can be best understood using the Biopsychosocial Model that was developed by George Engel in 1977, who believed that to comprehend and respond adequately to patients' suffering and to give them a sense to be understood, clinicians should attend simultaneously to the biological, psychological and social dimensions of illness. Engel is of the view that many factors interact to produce disease. His model is a framework for understanding health and disease that offers a holistic alternative to biomedical model. While traditional biomedical models of clinical medicine focus on pathophysiology and other biological approaches to disease the biopsychosocial model emphasize the importance of understanding human health and illness in their fullest contexts (Borrell-Carrio et al. 2004). The purpose of the biopsychosocial model is to take a broad view, to assert that, simply looking at the biological factors alone, which had been the prevailing view of disease is not sufficient to explain health and illness.

According to Engel's model biopsychosocial factors are involved in the causes, manifestation, course and outcome of health and disease including mental disorders. The model reflects the development of illnessthrough complex interaction of biological (genetic, biochemical) psychological (mood, personality, behaviour) and social factors (culture, familial, socioeconomic, poverty). Research has shown that risk factors for common mental disorders in the developing world are very much the same as those of the developed world, with poverty, stressful life events and female gender as the prominent risk factors. This model gives an adequate explanation on the causes of mental illness among women in Zimbabwe since chromosomal, psychological and social factors can contribute to causing mental illness. For instance, women encounter a plethora of biopsychosocial problems, including having

genetic dispositions to mental illness, stressful events, difficulty family backgrounds, poverty, domestic violence, intimate partner violence, physical mental problem, among others that result in causing mental health problems.

Gender and women's mental health

Though the overall prevalence of mental disorders is approximately the same among women and men, anxiety and depressive disorders are more common among women, while substance abuse disorders are among men (Stravropoulou & Samuels, 2015; O'Brien, 2012). In Zimbabwe, gender is a powerful social determinant of health that interact with other variables such as age, family structure, income, education, and social support. Also gender determines the differential control and power men and women have over socioeconomic determinants of their mental health and lives, their social position, status and treatment in society and their susceptibility and exposure to specific mental health risk (WHO, 2005; Gajendragad, 2015). Across many nations, cultures and ethnicities, from early adolescence through adulthood, women are twice likely as men to experience depression (Nolen-Hoeksema, 2001; Albert, 2015; O'Brien, 2012). Albert (2015:219) noted that "the prevalence of major depression is higher in women than in men; in 2010 its global annual prevalence was 5.5% and 3.2%, respectively representing a 1.7 fold greater incidence than men".

The prevalence of depression in both men and women in terms of age differences is more common in girls than boys but this ratio decreases with age (Albert, 2015). Girls are no more likely than boys to evidence depression in childhood, but by about 13, girls' rates of depression begin to increase sharply whereas boys' rate of depression remain low and may even decrease (Nolen-Hoeksema, 2001; Albert, 2015). Studies have repeatedly shown that gender-based differences contribute significantly to the higher prevalence of depression and anxiety disorders in girls and women when compared to boys and men, for instance, lower self-esteem of adolescent girls when compared to boys in the same age group, and anxiety over their body image is known to result in a high prevalence of depression and of eating disorders in adolescent girls than adolescent boys. At ages over than 65, both men and women show a decline in depression rates, and the prevalence becomes similar (Pattern et al, 2006 in Albert, 2015). Therefore, the rates of depression in men and women vary considerably across the life span.

Nolen-Hoeksema (2001) posits that stressful events cause traumas which may contribute directly to depression by making women feel hopeless and helpless to control their lives, and may also contribute indirectly, by increasing women's responsiveness to stress. (WHO, 2002). In this regard societal awareness of trauma caused by gender based differences and its willingness to combat them are of critical importance in the promotion of women's mental health. Due to the fact that women lack social power, this makes them more vulnerable than men to specific major traumas in particular sexual abuse. Globally sexual violence is experienced more by girls and women and there is a strong correlation between being sexually abused in childhood and the presence of multiple mental health problems later in life (WHO, 2002). Research indicates that there is a strong association between gender-based violence and mental health. Depression, anxiety and stress related syndromes, dependence on psychotropic medication and substance use and suicide are mental health problems associated with violence in women's lives (WHO, 2002; Albert, 2015; American Psychiatric Association, 2017).

Socially constructed gender roles, norms and responsibilities also carry a number of long-lasting strains that may directly contribute to low morale and high stress levels. They place women far more frequently than men in situations where they have little control over important decisions over their lives (Nolen-Hoeksema, 2001; WHO, 2002; American Psychiatric Association, 2017).Studies also revealed that the distress caused to women by factors such as arranged marriages, unwanted abortions, in-law problems and an enforced nurturing role precipitates psychological disorders(WHO, 2002; WHO, 2005). Mental illness also places an enormous burden on female relatives who care for the patient, for instance, emotional burden, financial costs and lost wages as well as diminished quality of life (WHO, 2002). This is exacerbated by socially determined gender roles that make women primary caregivers in many settings while giving them less social support to perform this function resulting in low morale and high stress level. Hence, socially prescribed expectations have considerable impacts on women's mental wellbeing.

Young (n. d.) argues that poverty, domestic isolation, powerlessness (resulting, for example, from low levels of education and economic dependence) and patriarchal oppression are all associated with higher frequency of mental disorders in women. Similarly a study that was conducted by Abas & Broadhead (1997) revealed that low income, poor educational achievement, lack of formal employment and overcrowding were all associated with cases of

depression and anxiety among women in Zimbabwe. Exposure of low income women to uncontrollable life events such as illness or death of children or husbands, imprisonment, job insecurity, dangerous neighbourhoods and hazardous workplaces put women at a significantly higher risk of depression than man (WHO, 2002; American Psychiatric Association, 2017). In the world of work, women do low paid and unpaid labour, contributing to oppression which causes depression. Women suffer the more since many of them work a double day, maintaining households, raising children carrying out economically productive activities in marketing and agriculture and in household based industries (Young, n..d). This shows that women work more hours than do their husbands given that they engage in diverse economic and household responsibilities which may lead to exhaustion and stress and eventually depression due to overworking.

Moreso, genetic and biological factors additionally play a role in the prevalence of mental health problems such as depression and anxiety in women. Mood swings related to hormonal changes as a part of menstrual cycle have been documented in studies. The fact that increased prevalence of depression correlates with hormonal changes in women, particularly during puberty, prior to menstruation, following pregnancy and at peri- menopause suggests that female hormonal fluctuations maybe a trigger of depression (Albert, 2015). In the case of antenatal and postnatal depression, the interaction of psychosocial factors with hormonal factors appears to result in an elevated risk, for example, marital disharmony inadequate social support and poor financial situation are associated with an increased risk of postnatal depression (WHO, 2002; Albert, 2015).

Mental health care in Zimbabwe

Though traditionally mental health has not been considered an immediate cause for concern in Africa, it is increasingly receiving more attention as the extent to which people suffer from various disorders has become apparent (Ofori-Atta et al. 2010; Demming et al., 2016). The desk review demonstrated that in Zimbabwe, there are numerous mental health institutions that offer various services such as acute mental illness, halfway home and rehabilitation, chronic mental illness as well as special forensic institutions. Table 1 shows a summary of mental health institutions in Zimbabwe.

Table 1: Summary of mental health institutions in Zimbabwe

Facility	Locality	Services Offered
Parirenyatwa Annexe	Harare	Acute Psychiatric Unit
Harare Psychiatric Unit	Harare	Acute Psychiatric Unit
Sakubva Unit	Mutare	Halfway Home/Rehabilitation
Ngomahuru Unit	Masvingo	Chronic Facilities
Mlondolozi Special Institution	Bulawayo	Special Institutions (Forensic facilities)
Harare Central Prison	Harare	Special Institutions (Forensic facilities)
Chikurubi Special Institution	Harare	Special Institutions (Forensic facilities)
Gweru General Hospital	Gweru	Acute Psychiatric wards in provincial hospitals
Chinhoyi Hospital	Chinhoyi	Acute Psychiatric wards in provincial hospitals
Marondera Hospital	Marondera	Acute Psychiatric wards in provincial hospitals
Mutoko Hospital	Mutoko	Acute Psychiatric wards in provincial hospitals

Source: Authors

Despite the fact that the country has a reasonable number of mental health institutions, there is a gap in the provision of holistic mental health services in communities due to deficiencyin delivering psychosocial supportservices.Social workers have the capability to fill in this gap in order to afford a comprehensive treatment to women living with mental illness.Theycan collaborate and network with other professionals and agencies in helping women with mental disorders improve their welfare through engaging these women in developmental activities.

Role of social work

The development of resilient, vibrant and health communities has been historically a tenet of social workers. Social work promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance wellbeing (Dalrymple & Boylan, 2013). The International Association of School Social Work, IASSW (2014) defines social work as a practice-based profession and an academic discipline that supports social change

and development, social cohesion, and the empowerment and liberation of the people through use of various theories techniques and principles. As such, social workers assume a number of roles in their attempt to bring social justice to the vulnerable, marginalised and socially excluded populations. Kurevakwesu (2017) argues that social work as a helping profession works to alleviate human suffering and distress and it challenges the underlying causes of social problems. As facilitators, counsellors, advocates and organisers, Zimbabwean social workers have an important role to play in helping women living with mental illnesses and their families to overcome barriers to their psychological and social wellbeing. Social workers also nurture the enthusiasm for transformation in clients through empowering them with knowledge, resources and capacity to self-direct and self-govern their lives and circumstances.Through social work interventions in communities that promote psychosocial support women living with mental illness' wellbeing can be enhanced. Without psychosocial support involvements for women with mental illnesses, a holistic treatment cannot be achieved. This can result in creating stringency in responding to the challenges they encounter at individual, family and community level.

Given that mental disorders may cause a range of psychosocial problems such as decreased quality of life for the patient and his/her family members as well as increased social distancing for the patient and family caring for the patientit is fundamental for social workers to take an active role in improving their circumstances (Iseselo et al. 2016). These challenges are enhanced by the stigma attached to mental illness, a problem not only affecting the patient but also the family. Psychosocial challenges are conditions and situations where a negative psychological state (feeling sad, feeling stressed, feeling irritable) is strongly related and influenced by the social environment in which people with mental illness are in (HealthNet TPO, 2011).A person who is stressed or upset interact differently with his environment (for example, due to feeling sad the person may neglect his/her children emotionally and financially). These psychosocial difficultiesexperienced by women with metal illnesses are often related to interpersonal problems such as domestic violence, relationship problems, family conflicts, and alcohol abuse among others.

Persons with mental illnesses may have trouble coping with emotions, stress, anger, and difficulties in handling daily activities, family responsibilities,relationships and work responsibilities. Similarly persons with mental illnesses often engage in behaviours that are frightening, troublesome, disruptive and annoying and many relatives are obliged to control,

manage and tolerate their behaviours and this can be draining psychologically and emotionally on the caregiver. Iseselo (2016) noted that psychosocial problems reduce the proper functioning of the family members taking care of the patient since they may feel overwhelmed by the patient's behaviour and this can lead to family members assuming critical attitude toward the patient. Such disapprovals can in some cases contribute to relapsing of the patient.Psychosocial support is fundamental in improving the social functioning of women living with mental disorders and their families as it involves the provision of essential services they need. Early and adequate psychosocial support can prevent distress and suffering becoming more severe and help people cope better and become reconciled to their daily activities. Through preventive, developmental and therapeutic interventions, the goal of psychosocial support is to help clients adjust psychologically and socially and increase their motivation in various aspects of their lives. Studies of psychosocial interventions with patients have shown that it results in improvement of mood, specifically depression, and other psychiatric symptoms while improving quality of life (Clark, 2010). The following sections look at how social workers can stimulate psychosocial wellbeing for individuals, families and communities.

Rehabilitation

Psychosocial rehabilitation encompasses a group of practices, including skills development, social skills training, family education, self-management, peer support, coping skills, self-monitoring training, vocational rehabilitation, education, and social and recreational development. The psychosocial rehabilitation is aimed at facilitating the development of an individual's skills in living and learning in social and work environments on developing the individual's ability decisions regarding self-care and on self-management of symptoms and medication (side effects). The main goal is attaining the psychosocial wellbeing of individuals and families through engaging them in rehabilitative and therapeutic activities, for instance, skills training workshops, sporting activities, or engaging them in educational workshops on self-esteem building. Social workers conduct a needs assessmentfor persons with mental disorders and their families, identifying problems that need attention and develop and implement psychosocial supportrehabilitative programmes in communities. Working collaboratively with people in their environments facilitates strength building and promotes empowerment which is fundamental in social work.

Counselling

Psychosocial counselling is a process of a dialogue and mutual interaction aimed at facilitating problem solving through motivation to enable a client to come up with a decision that solve the problem. The social worker and the client(s) involve themselves in a dynamic process of interaction in which the counsellor helps the client(s) to make a decision. Using counselling theories social workers provide counselling services to individuals, families and groups. Individual counselling involves the client and counsellor working together on solving problems that are very personal to confront in the presence of other people. The goal of this therapeutic relationship is to help the client have a realistic self-perception and have greater confidence and self-direction. As well the client is facilitated to develop social skills, an adaptive behaviour and a sense of positive worth. Individual counselling should also result in helping the client better cope with stress and become more fully functioning in all aspects of his/her life.This can be achieved by means of family, group and individual therapy.

Family therapy helps family members to resolve issues among each other as well as helping a family member who is not well to get well. This can be achieved by assisting the family to gain awareness of patterns of relationships that are not working well and create new ways of interacting to relieve stress. Through family therapy, family members learn how some ways of action and communication can worsen problems. The counsellor helps the family to come up with new improved ways of communicating and treating each other which can be explored and practised.

In group therapy people come together as a group and discuss their problems. Group members share problems and solutions to their problems, this gives them an understanding of personal problems and the ability to explore possible solutions. Group counselling gives room for people to confide with others and understand their struggles. The group therapy allows members to learn how they perceive themselves and how they are seen by others and improve their ability to identify their feelings regarding the problems they will be facing. It reduces isolation and encourages members to air their sentiments since they will have a permissive environment to practice communication skills in a safe setting.Members of the group will gain strength as they will realise that they are not the only ones going through problems, thereby cultivating resilience in them.

Advocacy

Mental health is a health area that has long been discriminated against that needs to be supported by affirmative action (Yasamy, 2008) Advocacy is the component of social work that greatly distinguishes it from other helping professions. Social workers seek equality, rights and opportunities for all vulnerable populations including people with mental illness.Women's mental health cannot be achieved without equal access to basic human rights: autonomy of the persons, education, safety, economic security, property and legal rights, employment, physical health including sexual and reproductive rights, access to health care and adequate food, water and shelter (Gajendragad, 2015). In addition, women's mental health requires elimination of violence based on sex, age, income, and religious beliefs among others. As professionals who work with people with mental health problems in communities, social workers play an indispensable role in promoting and protecting the wellbeing and welfare of women living with mental disorders. They play an imperative role inhelping women living with mental disorders to access legal care in line with the rights, privileges and benefits guaranteed for them. Connecting individuals and families with available services helps peopleparticipate fully in their communities.

Community awareness

Social workers also promote psychosocial wellbeing of women living with mental disorders through community sensitisation. For individuals living with mental illness and their families to be accepted as they are without stigmatisation, social workers initiate educational programmes aimed at enlightening communities, promoting mental health through mainstream health campaign activities, establishing preventive mental health programmes as a component of care provision to people at risk of mental health problems, and promoting research. All these are essential to promote better mental health outcomes for women. Social workers have the capacity to appropriately address stigma problems attached to mental illness, thereby creating communities and societies that are compassionate that can genuinely promote the realisation of social justice, equity and rights of women living with mental illnesses.

Conclusion

This article has conceptualised mental health and mental illness and showed that these two issues are interconnected. As well the article explored the several dimensions of the causes of

mental illness among women as provided by the biopsychosocial model citing biological, psychological and social factors as determinants of mental health problems. Though men and women are roughly affected by mental illness slightly differently, depression and anxiety are more prevalent in women. Variables such as age, societal expectations, poverty and education among others also interplay with gender in determining women's mental health. Ultimately, the article examined the role of social work in promoting the psychosocial wellbeing of women living with mental illness and the families. Social workers play a crucial rolein enhancing the lives of vulnerable, marginalised and discriminated groups. Counselling and rehabilitative services provided by social workers help women with mental illness to realise their full potential and become productive members of the society. Counselling also enables caregivers to learn how to treat and live with the mental health patients peacefully and harmoniously, becoming more supportive than being judgemental.Peer support helps patients to share problems with persons encountering the same problems as they do and come up with solutions to their problems and live fulfilling lives. In many communities the world over women living with mental illness are shunned and discriminated against, social workers should advocate for the rights of women living with mental disorders and also develop and implement educative programmes to sensitise communities about mental illness and how it can be prevented. Communities that accept and value women with mental illness help them to develop their self-esteemand a sense of worthy. As a result they will participate in the development of their communities. Social workers should also undertake extra research in mental health in order to keep abreast with the changing trends in modern ways of living and how they impact on women's mental wellbeing, then develop intervention strategies aimed at alleviating the challenges they encounter.

REFERENCES

Abas, M. A. & Broahead, J. C. (1997). Depression Among Women in an Urban Setting in Zimbabwe. *Psychological Medicine,* 27: 57-71.

Albert, P. R. (2015). Why Depression is More Prevalent in Women. *Psychiatry Neuroscience,* 40 (4): 219-221.

American Psychiatric Association. (2017). Mental Health Disparities: Women's Mental Health. Available from www.psychiatry.org/psychiatrists/cultural-competency Accessed 12/04/2020.

Australian Government's HealthInsite. (n. d.). What is Mental Health? Available from www.health.gov.au/mental-health Accessed 30/04/2020.

Bird, P., Omar, M., Doku, V., Lund, C. Nsereko, J. R. Mwanza, J. & MHAPP Research Programme Consortium. (2011). Increasing the Priority of Mental Health in Africa: Findings from Qualitative Research in Ghana, South Africa, Uganda and Zambia. *Health Policy and Planning,* 26: 357-368.

Borrell-Carrio, F., Suchman, A. L. & Epstein, R. M. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice and Inquiry. *Annals of Medicine,* 2 (6): 576-582.

Canadian Mental Health Association. (2002). Discrimination Against People with Mental Illness and their Families: Changing Attitudes, Opening Minds. Available from www.cmha-bc.org Accessed 02/05/2020.

Chibanda, D., Mesu, P., Kajawu, L., Cowan, F., Araya, R. & Abas, M. A. (2011). Problem Solving Therapy for Depression and Common Mental Disorders: Piloting a Task-shifting Primary Mental Health Care Intervention in a Population with a High Prevalence of People Living with HIV. *BMC Public Health,* 11: 1-10.

Clark, P. G. (2010). Decreasing Psychological Distress in Cancer Patients Using FLEX Care: A Pilot Study. *Social Work in Health Care.* 49 (9): 872-890.

Dalrymple, J. & Boylan, J. (2013). Effective Advocacy in Social Work. London: Sage Publications.

Demming, A., Gastfriend, E., Holleran, L. & Wang, D. (2016). Mental health in Sub-Sahara Africa. Available from www.havardea.org.blog.pdf.mentalillness Accessed 10/04/2020

Engel, G. & Ramano, J. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science,* Vol 196 (4286): 129-136.

Gajendragad, J. M. (2015). Struggles of Women with Mental Illness. *Journal of Humanities and Social Science,* 20 (4): 37-41.

HealthNet TPO. (2011). Building Capacity in Mental Health and Psychosocial Care: A Training Manual for Health Care Workers and Community Worker in Refugee Setting in the African Great Lake Area. Geneava: UNHCR.

Huggett, C., Birtel, M. D., Awenat, H., Fleming, P., Wilkes, S., Williams, S. & Haddock, G. (2018). A Qualitative Study: Experiences of Stigma by People with Mental Health Problems. Psychology and Psychotherapy: Theory Research and Practice. Available from www.wileyonlinelibrary.com Accessed 12/05/2020.

IASSW. (2014). Definition of Social Work. Available from http://www.iassw.orgAccessed 15/12/19.

Iseselo, M. K., Kajela, L. O. & Yahya-Malima, K. I. (2016). The Psychosocial Problems of Families Caring fo Relatives with Mentall illnesses and their Coping Strategies: A Qualitative Urban Based Study in Dares Salam, Tanzania. *BMC Psychiatry***,** 16: 1-12.

Johnstone, M. J. (2001). Stigma, Social Justice and the Rights of the Mentally Ill. Challenging the Status Quo. *Australian and New Zealand Journal of Mental Health Nursing,* 10: 200-209.

Kurevakwesu, W. (2017). The Social Work Profession in Zimbabwe: A Critical Approach on the Position of Social Work in Zimbabwe's Development. *Asian Journal of Social Science,* 8 (1): 1-19.

Macleod, J. & Smith D. G. (2003). Psychological Factors and Public Health: A Suitable for Treatment. *Epidemiol Community Health*, 57: 565-570.

Mangezi. W. & Chibanda, D. (2010). Mental Health in Zimbabwe Country Profile. *International Psychiatry,* Vol 7 (4): 94-96.

Ministry of Health and Child Care. (2016). Mental Health in Zimbabwe. Harare: Government Press.

Missouri Department of Mental Health. (2011). A Guide to Brain Disorders, Medication and Therapy. Jefferson: Department of Mental Health.

Monteiro, N. M. (2015). Addressing Mental Illness in Africa: Global Health Challenges and Local Opportunities. *Community Psychilogy in Global Perspective,* 1 (2): 78-95.

Nolen-Hoeksema, S. (2001). Gender Differences in Depression. *American Psychological Society,* 10 (5): 173-176.

O'Brien, W. (2012). The Recovery Imperative: A Critical Examination of Mid-life Women's Recovery from Depression. *Social Science and Medicine,* 75: 573-580.

Ofori-Atta, A., Cooper, S., Akpala, B., Osei, A., Doku, Y., Lund, C., Fisher, A. & The MHAPP Reseach Programme Consortium. (2010). Common Understanding of Women's Mental Illness in Ghana: Results for a Qualitative Study. *International Review of Psychiatry,* 22 (6): 589-598.

Stavropoulou, M. & Samuels, F. (2015). Mental Health and Psychosocial Services Provision For Adolescent Girls in Post Conflict Setting. London: UKaid.

Substance Abuse and Mental Health Services Administration. (2012). Available from www.samhsa.gov Accessed 24/04/2020.

Thornicroft, G., Rose, D. & Kassam, A. (2007). Discrimination in Health Care Against People with Mental Illness. *International Review of Psychiatry,* 19 (2): 115-122.

WHO. (2013). Mental Health: Strengthening our Response. Available from www.who.int/mediacentre/factshees/fs220/en/ Accessed 28/04/2020.

WHO. (2012). Risks to Mental Health: An Overview of Vulnerabilities and Risk Factors. Background Paper by Who Secretariat for the Development of a Comprehensive Mental Health Action Plan. Geneva: WHO.

WHO. (2011). Mental Health Alas. Geneva: WHO.

WHO. (2005). Gender in Mental Health Research. Geneva. WHO.

WHO. (2004). Promoting Mental Health: Concepts Emerging Evidence Practice (Summary). Geneva: WHO.

WHO. (2002). Gender and Mental Health. Geneva: WHO Department of Gender and Women Health.

Yasamy. M. T. (2008). Mental Health Challenges and Possible Solutions. *Eastern Mediterranean Health Journal.* 14 Special Issue: 114-122.

Young, J. L. (n. d.). Women and Mental Health. Available from www.psychologytoday.com/us/experts/joel-young-md Accessed 02/05/2020 Accessed 20/04/2020.