5.1 SUMMARY

Women with a portion to over of half population in the world, especially in developing country like India, should take into consideration any community based mental health programs. Women’s significant roles in global development of society, child rearing, family endorsement and workplace, their mental health influence by many socio-cultural factors (Navabi-Nejad, 2000). In contrast to women’s participation as the paid labor force during the recent decades that increased in country too, the major lines of women’s psychology investigation has mostly focused to the effects of child care and maternal employment in children rather than their psychic well-being (Khodarahimi, 2005). While universal growing literature has examined the effect of women's multiple roles on their own physical and mental health, and indicated their multiple roles have negative health outcomes for them.

Women are integral to all aspects of society. However the multiple roles that they play in society render them at greater risk
of experiencing mental problems than others in the community. Women bear the burden of responsibility associated with being wives, mother and career minders of others. Increasingly, women are becoming an essential part of the labour force and in one quarter to one third of households they are the prime source of income. In addition to many pressures placed on women, they have to bear gender discrimination and the associated factors of poverty, hunger, malnutrition and overwork. An extreme but common expression of gender inequality is in sexual and domestic violence, perpetrated against women. These forms of socio-cultural violence, contribute to the high prevalence of mental problems experienced by women.

Mental illnesses affect women and men differently — some disorders are more common in women, and some express themselves with different symptoms. Scientists are only now beginning to tell apart the contributions of various biological and psychosocial factors to mental health and mental illness in both women and men.

- Mental health problems affect women and men equally, but some are more common among women. Abuse is often a
factor in women’s mental health problems. Treatments need to be sensitive to and reflect gender differences. The same numbers of women and men experience mental health problems overall, but some problems are more common in women than men, and vice versa. Various social factors put women at greater risk of poor mental health than men.

RESTATEMENT OF THE PROBLEM

Mental illness in all cultures affects the quality of life of people. Contrary to widely held beliefs, people with mental illness are equally disabled like those with common chronic physical conditions. To ensure that the assistance available to those seeking treatment is meaningful, the patients' psychosocial and mental health needs must be addressed at full range. For women services have to be made genuinely accessible. It is not an easy task to improve the mental health of a population. It involves multiple decisions. Priorities should be set among the needs, conditions, services, treatments, preventive and curative strategies.

The present investigation is entitled as Women and Mental Health.
Women with mental illness were selected attending outpatient care in the said hospitals, the number is less for obvious reasons as has been mentioned earlier.

**OBJECTIVES OF THE STUDY**

The specific objectives of the study were;

- to study the socio-demographic correlations of the women in the sample regarding the morbidity patterns, help seeking behaviour and utilization of mental health services,
- to study the coping patterns adopted by women patients,
- to study the social burden experience by the families of women patients,
- to study the family careers orientation towards mental illness, and
- to study the implications for social work practice

**DESIGN OF THE STUDY**

For the present study descriptive research design was found suitable. However, following research hypotheses were framed depending upon objectives of the study. It was a fond desire for the researcher to study the mentally distressed and their problems.
Being in a small city did not deter the researcher from enquiring into such turbulent issues for entire family and society, as well. Further, being a woman herself the researcher could empathize with patients and caretakers. Sample may appear small but the reasoning is the availability and suitability of the individuals studied including caretakers. It sure was a difficult task catching hold of people and to extract information.

**SAMPLING**

The study aimed to understand the patterns of knowledge level of women suffering from various morbidity, the pathway taken to utilize the available services. The study also proposed to know the social burden faced by the family and coping patterns adopted by patients and caretakers respectively.

**Table : Sampling Design**

<table>
<thead>
<tr>
<th>Particulars</th>
<th>Hospitals</th>
<th>Total Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Al-Ameen Medical College, Bijapur</td>
<td>100</td>
</tr>
<tr>
<td>Patients</td>
<td>BLDES Medical College, Bijapur</td>
<td>200</td>
</tr>
<tr>
<td>Family members/Caretakers</td>
<td>100</td>
<td></td>
</tr>
</tbody>
</table>
For the present study purposive sampling technique was used. Data for the study was collected from the patients attending the OPD as well as in-patients in the psychiatric wards of hospitals in Bijapur city. Along with this, one member from patients’ families also was consulted to cull out the proper data pertaining to subject on hand namely caretakers point of view.

**VARIABLES**

In the present investigation, it was intended to study Women and Mental Health.

- **Dependent Variables:**
  
  I. **Social burden and its dimensions that is**

  1. Impact of well being,
  2. Impact on marital relationships,
  3. Application for caring,
  4. Impact on relationships with others
  5. Perceived severity of the disease

  II. **Orientation towards mental illness and its dimensions that is**

  1. Folk belief,
  2. Psychosocial stressor,
  3. Organic causation,
4. Non-restrictive behavior,
5. Weak cognitive control,
6. Fidgety behavior,
7. Bizarre behavior,
8. Folk therapy,
9. Psychosocial manipulation,
10. Physical method of treatment,
11. Hopelessness,
12. Hypo-functioning and
13. Rejection of mentally ill

**Independent Variables :**

1. Age groups (<25, 26-50, >50)
2. Relations with patient (mother, sister/brother, husband and others)
3. Gender (male and female)
4. Religion (Hindu, non-Hindu)
5. Educational qualifications (illiterates, up to secondary, degree)
6. Occupations (employed, housewife, others)
7. Income groups (<1 lakh, above 1 lakh)
8. Nature family (Joint, nuclear)
9. Types of marriage (arranged, unmarried)

10. Current place of residence (Parents, husband, others)

FORMULATION OF HYPOTHESES

The hypotheses framed for the study are as follows based on the objectives:

1. There is no significant difference between age groups (<25, 26-50, >50) with respect to self reporting and coping pattern about mental illness of patients.

2. There is no significant difference between relations with patient (mother, sister/brother, husband and others) with respect to self reporting and coping pattern about mental illness of patients.

3. There is no significant difference between male and female with respect to self reporting and coping pattern about mental illness of patients.

4. There is no significant difference between religion (Hindu, non-Hindu) with respect to self reporting and coping pattern about mental illness of patients.

5. There is no significant difference between educational qualifications (illiterates, up to secondary, degree) with respect
to self reporting and coping pattern about mental illness of patients.

6. There is no significant difference between occupations (employed, housewife, others) with respect to self reporting and coping pattern about mental illness of patients.

7. There is no significant difference between income groups (<1 lakh, above 1 lakh) with respect to self reporting and coping pattern about mental illness of patients.

8. There is no significant difference between nature family (Joint, nuclear) with respect to self reporting and coping pattern about mental illness of patients.

9. There is no significant difference between types of marriage (arranged, unmarried) with respect to self reporting and coping pattern about mental illness of patients.

10. There is no significant difference between current place of residence (Parents, husband, others) with respect to self reporting and coping pattern about mental illness of patients.

11. There is no significant difference between male and female care takers with respect to burden of mental illness of patients and its dimensions scores that is Impact of well being, Impact on
12. There is no significant difference between male and female care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

13. There is no significant difference between age groups (<25years, 25-50years, >50years) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

14. There is no significant difference between age groups (<25years, 25-50years, >50years) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior,
Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

15. There is no significant difference between relations (mother, husband, others) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

16. There is no significant difference between relations (mother, husband, others) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

17. There is no significant difference between Hindu and Non-Hindu care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring,
Impact on relationships with others and Perceived severity of the disease

18. There is no significant difference between Hindu and Non-Hindu care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

19. There is no significant difference between unmarried and married care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

20. There is no significant difference between unmarried and married care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk
therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

21. There is no significant difference between educational qualifications (illiterates, up to secondary, degree) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

22. There is no significant difference between educational qualifications (illiterates, up to secondary, degree) of care takers with respect to orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

23. There is no significant difference between occupations (employed, housewife, others) of care takers with respect to burden scores of mental illness of patients and its dimensions
that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

24. There is no significant difference between occupations (employed, housewife, others) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

25. There is no significant difference between type of marriage (arranged, unmarried) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

26. There is no significant difference between type of marriage (arranged, unmarried) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-
restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill.

27. There is no significant difference between income groups (<1 lakh, >1 lakh) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease.

28. There is no significant difference between income groups (<1 lakh, >1 lakh) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill.

29. There is no significant difference between types of family (joint, nuclear) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well
being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

30. There is no significant difference between types of family (joint, nuclear) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

31. There is no significant difference between current place of residence (parents, husband, others) of care takers with respect to burden scores of mental illness of patients and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease

32. There is no significant difference between place of residence (parents, husband, others) of care takers with respect to Orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-
restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill

33. There is no significant relationship between burden scores and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease with orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill scores of care takers

34. There is no significant relationship between self reporting and coping pattern about mental illness of patients with burden scores and its dimensions that is Impact of well being, Impact on marital relationships, Application for caring, Impact on relationships with others and Perceived severity of the disease scores of care takers
There is no significant relationship between self reporting and coping pattern about mental illness of patients with orientation towards mental illness and its dimensions that is Folk belief, Psychosocial stressor, Organic causation, Non-restrictive behavior, Weak cognitive control, Fidgety behavior, Bizarre behavior, Folk therapy, Psychosocial manipulation, Physical method of treatment, Hopelessness, Hypo-functioning and Rejection of the mentally ill scores of care takers

**COLLECTION OF DATA**

Bijapur has two big hospitals with medical colleges (Al-Ameen and BLDEA’s). Attempts were made to understand the patterns of utilization of the mental health services by women. Besides this the social burden faced by the family and coping patterns adopted were also studied.

The study proposed to explore the utilization of mental health services by women. This investigation mainly aimed at studying the socio-demographic characteristics, awareness about mental illness and pathways followed before accessing the services from the Government and Private hospitals for mental care. The study is primarily descriptive in nature and aims at throwing light on the
dynamics of influencing factors in utilizing mental health services by women. The data was collected from 100 mentally ill patients and 100 caretakers from the two hospitals as mentioned. The lists of patients enrolled in the OPD of the two hospitals were obtained with the help of Psychiatric Social Workers.

The present study may throw light on dark sides of the so far unknown patterns of behaviour to utilize the available mental health services in this part of Karnataka. The data had to be elicited both from patients and parents /family member/caretakers simultaneously. The total sample was 200 of which 100 were women patients and family members were 100.

**TOOLS USED FOR THE STUDY**

The following tools were used for collection of data:

- Socio demographic scale was developed by the investigator
- Self Reporting Questionnaire was developed by World Health Organization (WHO) (1994)
- Social Burden by Hell, Thara, Padmavati and Kumar (1998)
- Orientation towards Mental Illness by Prabhu (1985)
- Coping checklist by Rao, Subbakrishna and Prabha (1989)
ANALYSIS OF DATA AND STATISTICAL TECHNIQUES USED

In order to test the hypotheses stated in this study the following statistical techniques were employed.

1. Socio-Demographic Data Analysis
2. Descriptive Analysis
   - Patient Data Related Tables
   - Caretakers Data Related Analysis
3. Differential Analysis
4. Correlation Analysis

5.2 FINDINGS OF THE STUDY

I. Findings of Descriptive Analysis

   Section I: Patient Data Related Tables

1. The patients belonging to 26-50 years of age group have higher scores on self reporting as compared to patients belonging to <25 years and >50 years of age group.

2. The patients belonging to <25 years of age group have higher scores on coping pattern about mental illness as compared to patients belonging to 26-50 years and >50 years of age group.
3. The husbands of patients have higher scores on self reporting and mothers of patients who have lesser self reporting followed by others.

4. The Sisters/Brothers of patients have higher scores on coping pattern about mental illness and mothers of patients who have lesser coping pattern about mental illness followed by others.

5. The married patients have higher scores on self reporting as compared to unmarried patients.

6. The unmarried patients have higher scores on coping pattern about mental illness as compared to married patients.

7. The patients belonging to hindu religion have higher scores on self reporting as compared to non-hindu patients.

8. The patients belonging to hindu religion have higher scores on coping pattern about mental illness as compared to married patients.

9. The illiterate patients have higher scores on self reporting and graduate patients who have lesser self reporting followed by up to secondary educated mentally ill patients.

10. The graduate patients have higher scores on coping pattern about mental illness and illiterate patients who have lesser
coping pattern about mental illness followed by up to secondary educated mentally ill patients.

11. The employed patients have higher scores on self reporting and housewife patients who have lesser self reporting followed by other mentally ill patients.

12. The employed patients have higher scores on coping pattern about mental illness and other patients who have lesser scores on coping pattern about mental illness followed by housewife mentally ill patients.

13. The patients belonging to >1lakh income groups have slightly higher scores on self reporting as compared to patients belonging to <1 lakh who income group have lesser self reporting.

14. The patients belonging to >1lakh income groups have slightly higher scores on coping pattern about mental illness as compared to patients belonging to <1 lakh who income group have lesser scores on coping pattern about mental illness. As far as income status of the family is concerned, the findings of the studies of Kermode (2007) and Patel (2008) go along with the findings of the present study.
15. The patients belonging to nuclear family have higher scores on self reporting as compared to patients belonging to joint family have lesser self reporting.

16. The patients belonging to joint family have higher scores on coping pattern about mental illness as compared to patients belonging to nuclear family who have lesser coping pattern about mental illness.

17. The arranged-married patients have higher scores on self reporting as compared to unmarried patients who have lesser self reporting.

18. The unmarried patients have higher scores on coping pattern about mental illness as compared to arranged-married patients who have lesser coping pattern about mental illness.

19. The patients living other than parents and husband have higher scores on self reporting as compared to those living with husband and living with parents.

20. The patients living with other than parents and husband have higher scores on coping pattern about mental illness as compared to those living with parents and living with husband.
21. The married patients have higher scores on coping pattern about mental illness as compared to unmarried mentally ill patients.

22. The patients belonging to Hindu religion have higher scores on coping pattern about mental illness as compared to non-hindu mentally ill patients.

23. The patients with up to secondary as education qualification have higher scores on coping pattern about mental illness as compared to illiterate mentally ill patients.

24. The patients with degree as education qualification have higher scores on coping pattern about mental illness as compared to patients who were illiterate.

25. The patients belonging to >1lakh income groups have higher scores on coping pattern about mental illness as compared to <1lakh income. The study conducted of Khodarahimi (2009) also goes hand in hand with findings of the present study as far as socio-demographic variables are concerned. Similarly, Barnett (1990) womens’ mental health, mental role etc which confirm the findings of the present study.

**Section II: Caretakers Data Related Analysis**
1. The male Caretakers have higher scores on burden of mental illness as compared to female Caretakers.

2. The male Caretakers have slightly higher scores on orientation towards mental illness as compared to female Caretakers.

3. The Caretakers belonging to <25 years of age group have higher scores on burden of mental illness as compared to Caretakers belonging to 25-50 years of age group followed by >50 years of age group.

4. The Caretakers belonging to >50 years of age group have higher scores on burden of mental illness as compared to Caretakers belonging to <25 years of age group followed by 25-50 years of age group.

5. The relationship of Caretakers with patients as other than mothers and husband have higher scores on burden of mental illness as compared to relationship of Caretakers with patients as husband followed by relationship as mothers.

6. The relationship of Caretakers with patients as other than mothers and husband have higher scores on orientation towards mental illness as compared to relationship of
Caretakers with patients as husband followed by relationship as mothers.

7. The Caretakers belonging to Hindu religion have higher scores on burden of mental illness as compared to Caretakers of non-Hindu religion.

8. The Caretakers belonging to Hindu religion have higher scores on orientation towards mental illness of mental illness as compared to Caretakers of non-Hindu religion.

9. The unmarried Caretakers have higher scores on burden of mental illness as compared to married Caretakers.

10. The married Caretakers have slightly higher scores on orientation towards mental illness as compared to female Caretakers.

11. The graduated Caretakers have higher scores on burden of mental illness as compared to Caretakers with up to secondary education and illiterate Caretakers.

12. The graduated Caretakers have higher scores on orientation towards mental illness as compared to Caretakers with up to secondary education and illiterate Caretakers.
13. The Caretakers other than employed and housewife have higher scores on burden of mental illness as compared to housewife Caretakers and employed Caretakers.

14. The Employed Caretakers have higher scores on orientation towards mental illness as compared to housewife Caretakers and Caretakers other than employed and housewife.

15. The unmarried Caretakers have higher scores on burden of mental illness as compared to arranged-married Caretakers.

16. The arranged-married Caretakers have higher scores on orientation towards mental illness as compared to unmarried Caretakers.

17. The >1 lakh income group Caretakers have higher scores on burden of mental illness as compared to <1 lakh income group Caretakers.

18. The >1 lakh income group Caretakers have slightly higher scores on orientation towards mental illness as compared to <1 lakh income group Caretakers.

19. The Caretakers living in nuclear family have higher scores on burden of mental illness as compared to Caretakers living in joint family.
20. The Caretakers living in nuclear family have higher scores on orientation towards mental illness as compared to Caretakers living in joint family.

21. The Caretakers of other than parents and husband have higher scores on burden of mental illness as compared to Caretakers as husband and Caretakers as parents.

22. The Caretakers of other than parents and husband have higher scores on orientation towards mental illness as compared to Caretakers as husband and Caretakers as parents.

II. Findings of Differential Analysis:

a. The Caretakers of patients belonging <25years age group have higher scores on application for caring burden as compared to 25-50years and >50years of age group.

b. The Caretakers of patients belonging <25years age group have higher scores on perceived severity of the disease as compared to >50years of age group.

2. The Caretakers of patients belonging >50years age group have higher scores on folk belief as compared to 25-50years and <25years of age group.
3. The Caretakers of patients belonging <25years age group have higher scores on psychosocial stressor as compared to 25-50years and >50years of age group.

4. The Caretakers of patients belonging >50years age group have higher scores on hypo functioning as compared to 25-50years of age group.

5. The relations of Caretakers as others have higher scores on application for caring as compared to Caretakers as mothers and husbands.

6. The relations of Caretakers as others have higher scores on impact on relationships with others as compared to Caretakers as mothers and husbands.

7. The relations of Caretakers as others have different folk belief as compared to Caretakers as mothers and husband.

8. The hindu Caretakers of patients have higher scores on burden of mental illness as compared to non-hindu Caretakers of mentally ill patients.

9. The hindu Caretakers of patients have higher scores on impact on relationships with others as compared to non-hindu Caretakers of mentally ill patients.
10. The graduate Caretakers of patients have higher scores on impact of well being as compared to illiterate Caretakers.
11. The graduate Caretakers of patients have higher scores on impact on relationships with others as compared to illiterate Caretakers.
12. The graduate Caretakers have higher scores on weak cognitive control as compared to secondary school and illiterate Caretakers.
13. The graduated Caretakers have higher scores on rejection of the mentally ill as compared to secondary school and illiterate Caretakers.
14. The Caretakers of patients with > 1lakh income has higher scores on impact of well being as compared to <1lakh income group.
15. The Caretakers of patients with < 1lakh income has higher scores on perceived severity of the disease as compared to >1lakh income group.
16. The Caretakers of patients living in nuclear family have higher scores on orientation towards mental illness as compared to Caretakers living in joint family.
17. The Caretakers of patients living in nuclear family have higher scores on folk belief as compared to Caretakers living in joint family.

18. The Caretakers of patients living in nuclear family have higher scores on psychosocial stressor as compared to Caretakers living in joint family.

19. The Caretakers of patients residing currently with parents have higher scores on perceived severity of the disease of mental illness as compared to those residing currently with other than parents and husband.

20. The Caretakers of patients residing currently with parents have higher scores on folk belief as compared to residing currently with parents and other than parents.

III. Findings of Correlation Analysis:
Results of Correlation Coefficient between Burden and its Dimensions with Orientation Towards Mental Illness and its Dimensions of Caretakers

The following relationships are found to be significant at 0.05% level of significance.

1. The orientation towards mental illness and dimension of burden that is impact of well being of Caretakers
2. The orientation towards mental illness and dimension of burden that is application for caring of Caretakers
3. The orientation towards mental illness and dimension of burden that is impact on relationships with others of Caretakers
4. The orientation towards mental illness and dimension of burden that is impact on relationships with others of Caretakers
5. The dimension of orientation towards mental illness that is folk belief and dimension of burden that is impact of well being of Caretakers
6. The dimension of orientation towards mental illness that is folk belief and dimension of burden that is impact on relationships with others of Caretakers
7. The dimension of orientation towards mental illness that is folk belief and dimension of burden that is perceived severity of the disease of Caretakers

8. The dimension of orientation towards mental illness that is psychosocial stressor and dimension of burden that is impact of well being of Caretakers

9. The dimension of orientation towards mental illness that is psychosocial stressor and dimension of burden that is application for caring of Caretakers

10. The dimension of orientation towards mental illness that is psychosocial stressor and dimension of burden that is impact on relationships with others of Caretakers

11. The dimension of orientation towards mental illness that is psychosocial stressor and dimension of burden that is perceived severity of the disease of Caretakers

12. The dimension of orientation towards mental illness that is non-restrictive behavior and dimension of burden that is impact of well being of Caretakers

13. The dimension of orientation towards mental illness that is non-restrictive behavior and dimension of burden that is impact on marital relationships of Caretakers
14. The dimension of orientation towards mental illness that is non-restrictive behavior and dimension of burden that is perceived severity of the disease of Caretakers

15. The dimension of orientation towards mental illness that is weak cognitive control and dimension of burden that is impact of well being of Caretakers

16. The dimension of orientation towards mental illness that is weak cognitive control and dimension of burden that is impact on marital relationships of Caretakers

17. The dimension of orientation towards mental illness that is weak cognitive control and dimension of burden that is impact on relationships with others of Caretakers

18. The dimension of orientation towards mental illness that is weak cognitive control and dimension of burden that is perceived severity of the disease of Caretakers

19. The dimension of orientation towards mental illness that is fidgety behavior and burden assessment of mental illness of Caretakers

20. The dimension of orientation towards mental illness that is fidgety behavior and dimension of burden that is impact of well being of Caretakers
21. The dimension of orientation towards mental illness that is fidgety behavior and dimension of burden that is impact on relationships with others of Caretakers
22. The dimension of orientation towards mental illness that is bizarre behavior and dimension of burden that is perceived severity of the disease of Caretakers
23. The dimension of orientation towards mental illness that is folk therapy and dimension of burden that is impact of well being of Caretakers
24. The dimension of orientation towards mental illness that is folk therapy and dimension of burden that is impact on relationships with others of Caretakers
25. The dimension of orientation towards mental illness that is psychosocial manipulation and burden assessment of mental illness of Caretakers
26. The dimension of orientation towards mental illness that is psychosocial manipulation and dimension of burden that is impact on marital relationships of Caretakers
27. The dimension of orientation towards mental illness that is psychosocial manipulation and dimension of burden that is impact on relationships with others of Caretakers
28. The dimension of orientation towards mental illness that is physical method of treatment and dimension of burden that is impact of well being of Caretakers

29. The dimension of orientation towards mental illness that is physical method of treatment and dimension of burden that is impact on marital relationships of Caretakers

30. The dimension of orientation towards mental illness that is physical method of treatment and dimension of burden that is application for caring of Caretakers

31. The dimension of orientation towards mental illness that is physical method of treatment and dimension of burden that is perceived severity of the disease of Caretakers

32. The dimension of orientation towards mental illness that is hopelessness and burden assessment of mental illness of Caretakers

33. The dimension of orientation towards mental illness that is hypo-functioning and dimension of burden that is impact of well being of Caretakers

34. The dimension of orientation towards mental illness that is hypo-functioning and dimension of burden that is impact on marital relationships of Caretakers
35. The dimension of orientation towards mental illness that is hypo-functioning and dimension of burden that is impact on relationships with others of Caretakers

36. The dimension of orientation towards mental illness that is hypo-functioning and dimension of burden that is perceived severity of the disease of Caretakers

37. The dimension of orientation towards mental illness that is rejection of the mentally ill and dimension of burden that is impact of well being of Caretakers

38. The dimension of orientation towards mental illness that is rejection of the mentally ill and dimension of burden that is impact on marital relationships of Caretakers

39. The dimension of orientation towards mental illness that is rejection of the mentally ill and dimension of burden that is impact on relationships with others of Caretakers

40. The dimension of orientation towards mental illness that is rejection of the mentally ill and dimension of burden that is perceived severity of the disease of Caretakers. Greer (2011) studied coping strategies and mental health of African women. The findings of the present study corroborate with findings of African study.
Results of Correlation Coefficient Between Self Reporting And Coping Pattern About Mental Illness Of Patients With Burden And Its Dimensions Of Caretakers

The following relationships are found to be significant at 0.05% level of significance.

- The coping of mentally patient and dimension of burden that is impact of well being of Caretakers
- The coping of mentally patient and dimension of burden that is impact on marital relationships of Caretakers
- The coping of mentally patient and dimension of burden that is impact on relationships with others of Caretakers.
- The relationships between coping of mentally patient and other dimensions of burden of Caretakers are found to be not significant at 0.05% level of significance.

Results of Correlation Coefficient Between Self Reporting And Coping Pattern About Mental Illness Of Patients With Orientation Towards Mental Illness And Its Dimensions of Caretakers

The following relationships are found to be significant at 0.05% level of significance.
• The self reporting of mentally patient and orientation towards mental illness of Caretakers

• The self reporting of mentally patient and dimension of orientation towards mental illness that is folk belief of Caretakers

• The self reporting of mentally patient and dimension of orientation towards mental illness that is weak cognitive control of Caretakers

• The self reporting of mentally patient and dimension of orientation towards mental illness that is hopelessness of Caretakers

• The self reporting of mentally patient and dimension of orientation towards mental illness that is hypo-functioning of Caretakers

• The self reporting of mentally patient and dimension of orientation towards mental illness that is rejection of the mentally ill of Caretakers

• The coping of mentally patient and orientation towards mental illness of Caretakers

• The coping of mentally patient and dimension orientation towards mental illness that is folk belief of Caretakers
• The coping of mentally patient and dimension orientation towards mental illness that is weak cognitive control of Caretakers

• The coping of mentally patient and dimension orientation towards mental illness that is hopelessness of Caretakers

• The coping of mentally patient and dimension orientation towards mental illness that is hypo-functioning of Caretakers

• The coping of mentally patient and dimension orientation towards mental illness that is rejection of the mentally ill of Caretakers

5.3 DISCUSSION AND CONCLUSION

Today, one faces an unprecedented opportunity for action regarding women’s mental health. India is in the process of transforming mental health care. Indeed, mental health services are in the process of becoming more focused on resilience, recovery, and the active participation of individuals in their own mental health promotion and treatment. The importance of gender-based differences in the risk, etiology, and treatment of mental illnesses is more clearly understood than ever before. These advances set the course for continued progress in our understanding of the unique
issues confronting the mental health of women and girls, and they lend urgency to our ability to translate increased knowledge and evidence-based methods into daily practices that can improve health outcomes. The purpose of these Action Steps for Improving Women’s Mental Health is to spur positive changes. The hope is that policy planners, healthcare providers, researchers, and others will take up its charge and help translate action into reality. In this way, one can promote improved mental health and a healthier future for the women and girls of India.

5.4 SOCIAL WORK IMPLICATIONS OF THE STUDY

The concept of family burden is often a 'gendered' notion, with the lion's share of primary care giving being provided by female relatives (Jenkins and Schumacher, 1999; St. Onge and Lavoie, 1997). In the present study, this is true for the parent caregiver group, where most of the caregivers were women. However, in the spouse caregiver group, there were more men, in the care giving role. Tap areas of emotional burden specific to spouses, such as the effect of the illness on the patient's ability to share responsibilities, sexual relations and the overall quality of the marital relationship.
Intervention programs of processional social work should address the specific needs of spouses. This can help to lower levels of distress in the spouse caregiver.

Caregivers who used denial as a coping strategy experienced greater burden as study has very conspicuously shown. Several studies have reported that the use of avoidance and denial coping methods results in greater burden and distress. (Hinrichsen and Lieberman,1999). On the other hand, caregivers who use less of denial are higher scores on wellbeing (Rammohan, et al.,2002). The caregivers in the present study were using denial as a coping strategy, despite being in contact with mental health services. This finding suggests that psychological intervention with family caregivers must focus on helping them to accept the illness and take a more active role. The psychological distress experienced by caregivers may have influenced their ratings of burden.

Providing care to a family member with a long standing mental illness such as schizophrenia causes significant disruption in several domains of family life. There are concerns specific to parents and spouses that need to be addressed. Family intervention programs for persons with schizophrenia, therefore,
must be sensitive to the needs of individual patients as well as caregivers.

There are psychiatric social work intervention techniques which will, it is hoped, may be quite handy in helping the women in distress. Women have to be treated as women separately and the treatment programmes would do well, if are aimed at alleviation of distress the women undergo, as mothers, sister, wife, widow or otherwise.

Professional social workers in this regard utilize the social work methods and skills as social case work, social group work, community organization at the right direction for better results to serve the families from disintegration.

**Specific Initiatives in Mental Health Services and Training**

1. Upgrade the quality of mental health services

Mental health services have a crucial role to play in alleviating suffering associated with psychiatric illnesses, emotional distress, psychological disorders, and behavioral pathology. Abused women, troubled children, those traumatized by political violence, those who have attempted suicide or are addicted to alcohol or narcotics, and especially those who
suffer acute or chronic mental illnesses can be helped substantially by competent mental health care. It is have seen how women suffer disproportionately from mental illnesses such as depression and anxiety, and dissociative disorders associated with sexual abuse, and yet these are the illnesses that competent clinicians may best help. With recent advances in psychiatric medications and specialized forms of psychosocial interventions, the potential for benefit is greater than at any time in history.

Yet mental health services in most societies are inadequate. Well-trained practitioners are scarce, drugs and psychosocial interventions are unavailable or of poor quality, and even where expertise and resources exist, they seldom reach into the communities where the needs are greatest. The human rights of the mentally ill are often severely compromised, and mental health care is too often associated with abusive social control. Financial investment is required for sustainable programs, and creativity is needed to build programs that join local resources with professional knowledge.
Mainstreaming a gender perspective in the mental health sector -- through educating women at all levels of society about the possibilities of mental health interventions and the potential for services and programs -- is central to the success of mental health program development. The development of community based programs may build upon the engagement of many women to their local communities and their commitment to community and family health. Formal mental health services, including rational drug policies for psychototropic medications and the reliable provision of adequate supplies at reasonable costs (selected generic antidepressants, antipsychotic and anticonvulsant drugs), must be complemented by non-medical support groups, consumer groups and healing institutions that provide crucial care in many communities.

2. Encourage systematic efforts to upgrade the amount and quality of mental health training for workers at all levels, from medical students to graduate physicians, from nurses to community health workers.
Essential to mental health programs is a small cadre of well-trained mental health professionals: psychiatrists, psychologists, social workers and psychiatric nurses. They are the ones who must lead efforts to establish priorities of mental health in medical education and health policy. Training primary care physicians, nurses and health workers in the recognition and appropriate referral and/or treatment of mental illness is central to expanding community services to meet needs. Specific training in diagnosis and management of psychiatric conditions is required to improve the quality of mental health services offered in primary care. And since community practitioners often depend almost exclusively on agents of pharmaceutical companies for new information on medications, initiatives in continuing education are needed to provide more basic training in the safe and effective use of psychotropic medications.

With appropriate training and supervision, nonphysician primary health workers can learn to diagnose, treat, and organize follow-up programs for a substantial fraction of cases of depression, anxiety and epilepsy, and can, with appropriate supervision, manage patients with chronic
schizophrenia in the community if their social welfare is provided. WHO has developed training programs and shown they can be effectively employed in societies as diverse as India, the Philippines, and Tanzania. In societies in which nonphysicians provide a substantial portion of primary care, specialized training activities are a cost-effective means of improving and extending mental health services.

Mainstreaming a gender perspective may build on the interests of many women professionals who have entered the field of mental health care as psychiatrists, psychiatric nurses, counselors and social workers.

3. Promote efforts to improve state gender policies, toward interdicting violence against women, and toward empowering women economically, and to make women central in policy planning and implementation of mental health services. Research should evaluate the mental health consequences of these programs for women, for children, and for men.

As noted earlier, investing in the health, education, and well-being of women is of high priority for improving the mental health of populations in low and middle income countries.
The World Bank’s 1993 World Development Report clearly demonstrates that educating women to primary school level is the single most important determinant of both their own and their children's health. World Mental Health (1995) indicates women’s education is an equally valuable investment for the mental health of women, men and children. Such education also renders women less likely to tolerate domestic violence and abuse, or the spending of substantial portions of the family income on drinking or gambling by their spouses. Educated women are also more likely to be receptive to and engaged, as equal partners, in public health programs.

Women throughout the world constitute the vast majority of caretakers of first and last resort for chronically disabled family members, including mentally retarded children, demented elderly, and adults suffering a major mental illness. Minimally, it is in a community’s long-term social interest to assist with this burden through formal health services. In addition, because women are critical to the success of health policies, their participation in formulating mental health policies should be encouraged, with governments, international organizations and NGOs defining avenues for
women to exercise leadership roles. Policies may be evaluated by women's groups not only in terms of how they support women's mental health but also in terms of the quality of services offered to women, children and men.

4. Direct efforts specific to primary prevention of mental disorders, and behavioral, psychosocial and neurological disorders. Such efforts would survey the scientific knowledge base, examine primary prevention activities around the world, address the cross-cultural relevance of prevention programs, and define training needs and related activities. Successful prevention programs call for the integration of biological and psychosocial factors, and the active promotion of proven preventive programs. In addition, prevention programs require an understanding of indigenous protective factors, such as the activities of caretakers of those who are ill and those local practices that enhance the mental and physical health and well-being of individuals and of communities. Listening to women, professional and lay, should help in identifying these factors.
5.5 SUGGESTIONS FOR FURTHER RESEARCH

The interdisciplinary studies concerning women health issues may be taken up for thorough investigations.

1. Studies to identify specific factors that contribute to gender related issues among other sectors may be undertaken (industry, administration bureaucracy, educational professionals etc.).

2. The present study covers mental health services for women. The study may be extended to other psychological problems with higher sample and area.

3. A comparative study of women and mental health issues with other professional women may be taken up.

4. The study may be extended to working womens problems of all sectors to know their adjustment to gender issues.

5. Comparative studies of women of different States and their psycho-social and physical problem related issues may be undertaken.

6. Comparative studies of gender related problems of mentally disturbed women working in major metropolitan cities and rural areas may be taken up.