STRESS TOLERANCE, COPING STYLES AND WELL-BEING OF WOMEN SPOUSES OF MENTALLY ILL

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Certificate

I, Dr. (Mrs.) Anita Ravindran, do hereby certify that this dissertation entitled "STRESS TOLERANCE, COPING STYLES AND WELL -BEING OF THE WOMEN SPOUSES OF THE MENTALLY ILL" is a record of bonafide study and research carried out by Mrs. Sandhya. C., under my supervision and guidance.

This research work has not been submitted by her for any award of degree or diploma in this or any other university before. The thesis embodies the results of the investigation conducted during the period of her work as a Ph.D. Scholar.

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DECLARATION

I, Sandhya. C. do hereby declare that this thesis entitled STRESS TOLERANCE, COPING STYLES AND WELL-BEING OF THE WOMEN SPOUSES OF MENTALLY ILL has not been submitted by me for any award of degree or diploma in this or in any other university.

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Chapter 1

Introduction

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Psychology of women has emerged as an interdisciplinary effort to understand the behavior of women. The various fields of psychology have explored the developmental paths that women follow, and have investigated the inner dynamics of their lives. In 1960s, there was an increase in empirical studies related to the psychology of women. Psychologists set out to determine what sex differences actually existed, causes of any such differences and key issues in women's lives and how these developed overtime (Forisha-Kovach, 1984). It was concluded that women are not so different from men as had been supposed, and differences may be explained by cultural and biological causes. It was seen that themes of individual achievement and interpersonal relationships are both important in women's lives and have a different relationship to each other depending on the individual, the time of life and cultural settings.

According to the feminist perspective, the psychological problems that women experience can only be understood in terms of the positions they occupy in the society. (Peterson,1996). This part is further highlighted by Davar (2003). She cites Khan and Yoder in discussing alpha bias (bias that men and women are naturally different) and beta bias (bias that men and women are the same) in psychological and feminist theories. Khan and Yoder say that they would prefer to assume a beta bias position but with the caveat that social factors rather than natural or biological ones have led to gender differences in mentality. Women do not have the same political and economic power that men do, and our society is structured in such a way that this gender biased hierarchy maintains itself.

While endorsing the socio-political argument of feminism, psychologists have discovered some basic predispositions that make men and women a little different. Karen Horney's theory on psychology of women opened doors for new way of understanding women's personalities and relationships. According to Symonds, as cited in Magill and Turner (1996), women are more eager to create new relationships, and women express more feelings when the relationship ends as compared to men. Symonds considered these behaviors from the view point of 3 basic modes of interaction described by Horney: moving toward, moving away from, and moving against. Symonds viewed the moving toward, self-efficacy type of behavior as love - oriented or dependent; the moving-away-from as detached type and freedom oriented; and the moving against as expressive type and power oriented. Women therefore are more inclined for the first-type

In the Indian cultural context, the only common sacrament performed for a woman is marriage, and hence it is featured to be the most important corner stone in a woman's life. Demands of personal gratification and pleasures are looked upon as aspects to be subordinated, and the individual is called upon to make marriage a success by means of compromise and adjustment. Ironically, it is the only platform for most of the women to utilize or prove her potential.

The assumption that a women's primary identity is that of a 'house maker' and house- wife' assigns to her not one, but three roles - wife, house-worker, and child rearer. A common belief is that these roles are naturally and inextricably linked and that they are 'naturally' performed by one person (Frost, 1977). However, working or non-working, majority of women willingly and unwillingly conform to this common belief. . When she is also saddled with a spouse who is mentally ill, there occurs telling effects on her stress tolerance, and coping styles she might adopt to manage the stress and on her sense of wellbeing.

However, under situations of additional demands such as illness in the family, child birth, death etc., care giving is not always confined to women alone. Sometimes, husbands also find themselves in the role of caregivers. Studies have shown that irrespective of gender, caregivers in the case of care giving for mentally ill experience profound burdens as a result of their interactions with the mental health care system, particularly in negotiating crisis situations, obtaining adequate community resources, continuity of care and information, dealing with legal barriers and communicating with mental health professionals. (Francell, Conn, and Gary, 1988). As care giving is a round-the-clock strenuous job, it is imperative that we have an adequate understanding of stress, stressors, stress tolerance and physiological as well as psychological aspects of stress. While each of the roles has its challenges to meet, the social change is continuously making more demands and thus becoming stressful for the woman of 21st century.

STRESS

"The term stress refers to situations that pose demands, constraints or opportunities" (Sarason and Sarason, 1996; p.128). "The term stress typically has been used to refer both to the adjustive demands placed on an organism and to the organism's internal biological and psychological responses to such demands" (Carson and Butcher, 1992, p.40). Weiten and Lloyd (2003) defined stress as any circumstances that threaten or are perceived to threaten one's wellbeing and thereby tax one's coping abilities. Stress occurs when demands exceed capacity. It is a state which arises from an actual or perceived demand - capability imbalance in the organism's vital adjustment which is partially manifested by a non specific response. It is a negative emotional experience associated with predictable biochemical, physiological, cognitive and behavioral changes that help the organism to alter the environment or adapt to it. With all its vices, stress at many times is a necessary positive force leading to effective work and maintenance of

good health. Insufficient stress might lead to "rust out" while over exposure to stressful conditions lead to "burn out".

Seyle (1983) has described 4 basic variations of stress each with its own label. When events have a harmful effect, stress is correctly labeled as *distress*. Beginning a new job, getting married or taking up an exciting sport like sky diving may have a stimulating effect that result in personal growth. This is *eustress*. *Hyper stress* or excessive stress usually occurs when events, including positive ones, pile up and stretch the limits of our adaptability. *Hypo stress* or insufficient stress is apt to occur when we are lacking stimulations.

Along with the understanding of stress it is also necessary that the concept of stressors are understood too.

Stressors

Stressors are challenges that can alter the workings of the body and perhaps affect the health, because of their meaning to the person and the effect of these meanings in the person's daily life (Lovallo, 2005). The impact of stressors depend on a number of factors - the importance of the stressor to the person, the duration of the stress, the cumulative effect of stressors in the person's life, whether the stressor is natural or artificial, and whether it has prominence in the person's life, and whether or not that stressor is seen by the victim as being within his/her control. (Carson, Butcher and Mineka, 2000). They further talked about different kinds of stressors, which pose different degrees of stress to different persons.

(a) **External stressors** include adverse physical conditions (pain, hot or cold temperatures) or stressful psychological events (poor working conditions or abusive relationships). Humans as well as animals can experience emotional stressors.

(b) **Internal stressors** can also be physical (infections or inflammations) or psychological. Internal psychological stressors are intense worry about a

harmful event that may or may not occur. Internal psychological stressors are rare or absent in most animals except humans.

(c) Acute stressors are the reaction to an immediate or suddenly occurring threat. The threat can be any situation that is experienced, even subconsciously or falsely as danger. Under most circumstances, once the acute threat has passed, the response become inactivated, and the levels of stress hormones return to normal.

(d) Chronic stressors include ongoing pressured work, long term relationship problems, loneliness and persistent financial worries. They are largely products of modern life. Here stressful situations are not short lived and action should be suppressed.

It has also been seen that stress and stressor are relative terms making it more complex and person-oriented. Therefore understanding stress tolerance becomes inevitable in the study of mental health.

Stress tolerance

"Stress tolerance refers to the person's ability to withstand stress without becoming seriously impaired". (Carson and Butcher, 1992, p.144). "stress tolerance may also be defined as the degree of stress you can handle or how long you can put up with a demanding task, without acting in an irrational disorganized way" (Atwater, 1994, p.116).Greater tolerance of stress usually comes with greater experiences and skill in a given task. Another important aspect of stress tolerance is the ability to function well without anxiety.

Stress in different groups

Differential effects of stress on various groups have been an area of investigation.(www.well-connected.com). Some of the groups who are susceptible towards the ill effects of stress are:-

(a) Children and adolescents:- Animal studies report that rats that have been exposed to maternal grooming have lower stress hormone levels even in childhood. Depressed or aggressive mothers are particularly powerful sources of stress in children - even more important than the effects of poverty or overcrowding. Children are frequent victims of stress, because they are often unable to communicate their feelings accurately, or their responses, to events over which they have no control.

(b) The elderly:- As people age, the ability to achieve a relaxation response after a stressful event becomes more difficult. Aging may simply wear out the systems in the brain that respond to stress so that they become inefficient. The elderly are very often exposed to major stressors such as medical problems, loss of spouse and friends, a change in the living situations and financial worries.

(c) Caregivers:- Caregivers of physically or mentally disabled family members are at risk for chronic stress. Spouses caring for a disabled partner are particularly vulnerable to a range of stress related health threats including influenza, depression, heart diseases and poor survival rates. Wives experience significantly greater stress from care giving than husbands and tend to feel more negative about their husbands, than care giving husbands feel for wives. Specific risk factors that put caregiver at higher risk for severe stress or stress- related illness include having a low income, helping a highly dependent patient, living alone with the patient, and having a difficult relationship with the patient.

(d) Women:- Studies in developed countries indicate that women maybe disproportionately affected by mental health problems (www.whosea.org). In India, studies in the early 1970s reported that the incidence of mental illnesses was higher among married women in the reproductive age group. Further they found that the more common mental illnesses like anxiety, histrionic disorder and depression affected more women than men (www.whosea.org/women2). Recent Indian studies have confirmed the

higher prevalence of psychiatric morbidity in women. A meta analysis of 13 epidemiological studies carried out in different parts of the country reported an overall prevalence rate of mental problems - minor and major combined - of 51.9/1000 population in men and 64.8/1000 population in women (www.whosea.org)

(e) Angry personalities:- People who are less emotionally stable, or have high anxiety levels tend to experience specific events more stressful than others. Type A personalities also falls under this category especially those who possess inadequate skills to deal with life's stress and strain. Also it has been seen that overloaded people are more stressful than people with fewer tasks to perform.

(f) People who lack a social network:- The lack of an established network of family and friends predisposes one to stress disorders and stress related health problems. Other groups of people who are vulnerable to the effects of stress are working mothers, less educated individuals, the unemployed, people who are targets of racial or sexual discrimination, and people who live in cities.

Why are events perceived as stressful?

Understandably enough, events have different meaning for different people. A number of features inherent in the events make the events stressful (Carson, Butcher, and Mineka, 2000).

- Negative events are more likely to produce stress than positive events
- Uncontrollable or unpredictable events are more stressful than controllable or predictable ones.
- Ambiguous events are often perceived as more stressful than clear cut events

- Individuals are more vulnerable to stress in central life domains than in peripheral ones.

However, apart from these inherent features, it is imperative that we try to understand the why of differences in the perception of events. This was explained by (McDonald and Brodsky, 1997) as follows:-

(a) Cognitive - costs hypothesis

Stress over-burdens one's perceptual and cognitive resources. This attentional overload occurs because the person must constantly monitor the environment for potential ways out of the stress. The person has to continuously gauge the stressful situation as well as formulate ways out of it. This continuous gauging and interpreting the situation and formulation of solutions render the event as stressful.

(b) Helplessness and stress

McDonald and Brodsky (1997) cites the observations of Maier and Seligman that uncontrollable and unpredictable stress produces feelings of helplessness. The result of this helpless feeling produces deficits in three domains namely motivational, cognitive and emotional. Motivational decrement causes the person to lose all the motivation to change the outcome of the stressful event. In cognitive decrement, the person fails to learn new responses that could help him avoid the aversive outcome. Emotional decrement brings about helpless feelings and the sense that the person does not have any control over events. This gives rise to mild or severe depression.

Effects of stress

In prehistoric times, the physical changes in response to stress were essential adaptations for meeting natural threats. Even in the modern world, the stress response can be an asset for raising levels of performance during critical events such as sports activity, an important meeting or in situations of

actual danger or crisis. If stress becomes persistent, all parts of the body's stress apparatus (the brain, heart, lungs blood vessels and muscles) become chronically over-or-under-activated. This may produce physical or psychological damage over time.

(a) Psychological effects of stress: -Empirical evidences reveal that the inability to adapt to stress is associated with the onset of depression and anxiety (McConnell, 1977). Repeated release of stress hormones produce hyperactivity in the HPA (hypothalamus-pituitary-adrenal) axis, and disrupts normal levels of serotonin, the nerve chemical that is critical for feelings of wellbeing and which accounts for sleep waking patterns. The disruption of serotonin levels can cause insomnia and a state of uncomfortable hyper arousal. Being subjected to prolonged stress also diminishes reaction time. It affects the rational judgment, concentration and memory. On a more obvious level, stress diminishes the quality of life by reducing feelings of pleasure and accomplishment, and relationships are often threatened.

(b) Physiological effects of stress: -When faced with stress, the body releases a number of different hormones. Some of these hormones, notably cortisol and adrenaline raise blood pressure and cholesterol levels and suppress immune system, putting oft-stressed people at greater risk for everything from colds to cancer to heart disease (Jaffe-Gill et.al. 2007). The steroid hormones dampen parts of the immune system, so that immune molecules can be redistributed to the body's frontline where injury or infection is most likely. This compromises the body's general health and ability to resist disease.

At this point the term coping and its several implications has to be taken into account in understanding the quality of life and wellbeing of the individual. Coping and one's repertoire of coping styles determine how well stress is managed to maintain the wellbeing.

COPING

Coping is the term that is much frequently used along with the term stress. No literature pertaining to stress will be complete without taking into understanding the concept of coping and its many faceted strategies and techniques involved in the process.

Coping has been defined as the process of making external or internal demands that are perceived as taxing or exceeding a person's resources (Lazarus and Folkman, 1984). Coping is any effort that seeks to preserve reality. It involves only conscious efforts to deal with the stressful demands (Sehgal and Sharma, 1998).

Many investigators have found that while the stress response may be influenced by numerous variables, appraisal of the stressors coupled with the individual's ability to cope with the challenge may represent particularly pertinent psychosocial factors in determining behavioral and biological outcome (Matheson and Anisman, 2003).

Approaches to coping

Coping behavior has been theorized in three approaches:-

(a) Psychoanalytic approach:- This approach focuses on the use of defense mechanisms. In the classical definition, defense mechanisms are designated as maladaptive and are not consciously chosen. However, DSM-4-TR (American Psychiatric Association) identifies seven major types of defense mechanisms and orders them from less to more adaptive. The most severe is defensive dysregulation or frankly, psychotic process involving projection, denial and delusion. In contrast, highly adaptive or mature defense mechanisms include altruism, humor and sublimation.

(b) Personality approach:- According to this approach, coping styles focuses more on how people process information. The earliest typology was repression - sensitization (Byrne, 1964). This dichotomy has reappeared in

many different guises over the past years as blunting - monitoring (Miller, 1980) and approach - avoidance (Roth and Cohen, 1986). In general, approach - monitoring coping styles have been shown to be associated with better outcomes in a variety of situations, while avoidant - blunting styles are associated with power outcomes. (Aldwin, 1999; Roth and Cohen, 1986).

(c) Cognitive process approach: - This coping process approach, drawing upon the cognitive behavioral perspective, argues that coping is flexible and responsive to environmental demands, as well as personal preferences. In this model, how individuals cognitively appraise the situations is the primary determinant of how they cope. The four primary appraisals are benign, threat, harm/loss, and challenge, and, they are influenced both by environmental demands and individual belief values and commitments (Lazarus and Folkman, 1984). Rather than examining general coping styles, coping process approaches examine how individuals cope with a particular stressor.

Dynamics of coping

Sharan (2000) has made a review of the different theoretical approaches to coping and has stated that the concept and its mechanism are better understood with the aid of different models of coping, which explores its dynamics.

(a) Model of appraisal and reappraisal :- Based on his empirical works, Lazarus has enunciated a theory of stress and coping that is widely accepted as the basis of understanding the process involved. In many ways appraisal is the corner stone of Lazarus' theory of stress and coping. As one encounter events or situations, they are evaluated and categorized as irrelevant, benign, positive or stressful. Primary appraisal entails an individual evaluating the situation as taxing resources and potentially problematic for his/her wellbeing. If a situation is appraised as stressful in the primary appraisal, then other parts of the coping process are invoked and secondary appraisal occurs. Thus appraisal represents the process both of

ascertaining that a situation is stressful, and determining what might be done to cope with the situation.

(b) Social problem solving model: - Much work in this area has been done by D'Zurrila, who has been concerned primarily with social problem solving, which he defines as the process by which individuals identify and implement effective solutions to problems in everyday life. He has analyzed the process into several conceptual stages which are involved in an effective solution to a (social) problem. These stages include

- Problem orientation - the manner in which the individual approaches the problem
- Problem definition and formulation - the ability to identify the relevant aspect of the situation
- Generation of alternative solution - the ability to develop different possible responses to a situation
- Decision making - the judgment, comparison and selection from among alternative responses generated
- Solution implementation and verification - enactment of the responses chosen and repetition or modification if the result is ineffective. This model highlights a set of cognitive and behavioral skills that are amenable to existing clinical techniques and which are applicable in a wide variety of problematic situations.

(c) Sense of coherence model: - Antonvsky has proposed the notion of sense of coherence as a personal disposition that determines the success of coping and adaptation. This global construct is intended to measure an enduring and pervasive feeling of confidence that one's environment is structured and predictable and that one has both resources and motivation to meet the demands it poses.

(d) Model of self efficacy: - Bandura's notion of self efficacy also overlaps with part of the coping process. Eventually, it proposes that an individual's expectation of how well he/she will be able to accomplish a challenging task is a major determinant, and therefore a good predictor of subsequent performance.

(e) Model of personal control:- Personal control is also a very broad construct that overlaps coping. It has been conceptualized in several ways by different authors, with some focusing on the beliefs people hold about control, and others concerned with behaviors that represent actual attempts at control. There is no doubt that beliefs about control can affect one's appraisal of a situation as a personal resource or as a constraint in the appraisal process. On the other hand, efforts at achieving control over stress are clearly instances of coping responses.

While the above said models have largely emphasized on the factors within the individual, the model put forth by Frydenberg (1997) posits that coping is a function of the situational determinants and the individual's characteristics, perception of the situation and coping interventions. The individual brings a host of biological, dispositional, personal and family history and family climate characteristics. It is how these influence the perception of the situation that is of interest. Following an appraisal of the situation, the individual assesses the likely impact of the stressor, that is, whether the consequences are likely to lead to 'loss', 'harm', 'threat', or 'challenge' and what resources are available to the individual to deal with the situation. The intent of the action, along with the action determines the outcome. Following a response, the outcome is reviewed or reappraised and another response may follow.

Frydenberg refers to the argument by Perez and Richards that in order to establish the effectiveness and appropriateness of concrete coping efforts, knowledge is required about the way an individual perceive the stressor and its consequences along with some knowledge relating to the

intent of coping actions. Maladaptive coping can be a result of perceptual or representational deficits, or a deficiency in coping resources. The argument put forward by the investigators is that there is a correspondence between the objective features of a situation, the subjective assessment by the individual, and the resources that are available in order that the appropriateness of the coping efforts can be determined. Maladaptive coping can be the result of perceptual deficits or non-availability of the resources.

Frydenberg further opines that there are direct attempts to deal with the problems when there is a belief that the situation will not change unless the individual does something to achieve the goal. However, when there is a belief that the situation is uncontrollable, then the individual will choose to avoid the situation. Given that there is a correspondence between the objective features of a situation, subjective assessment and the available resources, it argues well for the development of interventions which attempt to change the perceptions and cognitions, and assist the individual to expand the range of coping strategies that is able to be harnessed to deal with the life encounter.

Coping styles

Coping styles refer to how a person appraises or evaluates a situation and the effort he/she makes to manage the associated personal feelings or to solve the problem (Aldwin, 1999). Coping styles have come to represent those strategies that are used more consistently rather than changeably, in the course of the person - environment interaction (Frydenberg, 1997). Thus the term is often associated with the trait conceptualization of coping. Coping styles generally refer to the actions that are used consistently by an individual to manage stress. Although there has been some inconsistency in the use of the term, coping style is typically the term used to refer to characteristic methods individuals use to deal with threatening situations (Manne, 2003).

Types of coping styles

Manne (2003) proposed that individuals differ in a consistent and stable manner in how they respond to threatening health information and how they react to it effectively. He reported different kinds of coping styles.

The monitoring coping style construct which has been put forth by Miller proposes that individuals have characteristic ways of managing stress in terms of their attention processes. According to this theory, there are two characteristic ways of dealing with stress - *monitoring and blunting.* Monitors scan for and magnify threatening cues, and blunters distract from and downgrade threatening information.

A similar coping styles construct that has received theoretical and empirical attention is coping with affective responses to stress. Two constructs - repressive coping styles is exhibited by individuals who believe they are not upset despite objective evidence to the contrary. Thus it is inferred that they are consciously repressing threatening feelings and concerns. This style has been variously labeled as *attention - rejection* by Muller and Suls, and as *repression-sensitization* by Byrne. A second, but related coping style, labeled by Watson and Greer, is the *construct of emotional control,* which describes an individual who experiences and label emotions, but does not express emotional reaction.

Although the majority of coping theories treat coping as a situational variable, a subset of investigators have conceptualized coping behavior as having trait -like characteristics. That is coping is viewed as largely consistent across situations, because individuals have particular coping styles and ways of handling stress. Manne (2003) discusses such relatively stable forms of coping styles under a few categories.

(a) Functional and dysfunctional coping

Coping is not inherently good or bad. Rather, coping can be characterized as consisting of productive and non productive strategies and

thus coping can be labeled functional and dysfunctional. Functional coping occurs when a problem is defined, alternative solutions are generated and actions are performed. Dysfunctional coping refers to the management and expression of feelings which may serve an important purpose, especially when dealing with events beyond a person's control, or where direct action is inhibited by external barriers. How productive and nonproductive strategies are perceived and utilized depends on contextual factors. Thus, what is productive in one circumstance is not in another, and similarly what is perceived as productive by one person is not for another. In addition to being situation specific, coping strategies may vary with the passage of the time and with changes within the individual (Matheson and Anisman, 2003).

(b) Defensive and constructive coping

Yet another classification cited by Worshen and Shebilske (1995), refers to two types of coping - defensive and constructive coping.

Defensive coping is a common response to stress. The concept has its root in the psychoanalytic tradition. People use a variety of defense mechanisms to protect themselves from painful emotions. Generally, defense mechanisms are poor ways for coping for a number of reasons- defensive coping is an avoidance strategy, and an avoidance rarely provides a genuine solution to problems; defenses such as denial, fantasy and projection represent wishful thinking which is likely to accomplish little; a repressive coping style which has been related to poor health in part because repression often lead people to delay facing up their problems.

The concept of constructive coping is simply meant to convey a healthy positive coping style, without compromising success. It involves confronting problems directly. It consists of a conscious effort to rationally evaluate options to solve problems. It is also based on reasonably realistic appraisals of stress and coping resources. Constructive coping involves learning to recognize and manage potentially disruptive emotional reactions to stress and also learning to exert control over potentially harmful or

destructive habitual behaviors. It requires the acquisition of some self control.

Weiten and Lloyd (2003) speak of constructive coping tactics as consisting of 3 strategies of coping: - appraisal focused strategy, problem focused strategy and emotion focused strategy.

(a) Appraisal focused strategy: - People often under estimates the importance of the appraisal phase in the stress process. They fail to appreciate the highly subjective feelings that color the perception of threat to one's wellbeing. A useful way to deal with stress is to alter one's appraisal of threatening events. Ellis theorizes that unrealistic appraisals of stress are derived from the irrational assumptions people hold. Faulty assumptions generate catastrophic thinking and emotional turmoil. Humor and positive thinking are also identified as constructive strategies of coping. Finding a humorous aspect in a stressful situation redefines the situation in a less threatening way. Apart from these, positive reinterpretation can facilitate calming reappraisals of stress without the necessity of distorting reality. Another way to engage in positive reinterpretation is to search for something good in a bad experience

(b) Problem focused strategy: - Problem focused constructive coping includes efforts to remedy or conquer the stress producing problem itself. Here, the first step is to clarify the nature of the problem. In the case of an obvious problem or in the case of not so obvious one, one needs to arrive at a specific concrete definition of the problem. The second step is to generate alternative courses of action. Besides avoiding the tendency to insist on solutions, one needs to avoid the temptation to go with the first alternative that comes to the mind. The third step is the evaluation and elimination of unrealistic possibilities, listing of probable consequences associated with each alternative, and review and comparison of the desirability of potential outcome. The final step is the implementation of the plan. Seeking help and

effective management of time are two other problems focused constructive coping strategies.

(c) Emotion focused constructive coping:- According to Maier and Seligman, emotional intelligence is the key to being resilient in the face of stress. Emotional intelligence consists of the ability to monitor, access, express and regulate one's own emotions; the capacity to identify, interpret and understand other's emotions; and the ability to use this information to guide one's thinking and action. The various coping strategies in emotion focused coping helps to release pent up emotions, manage hostility and forgive others, meditate and use relaxation procedure.

(c) Transformational and regressive coping

Maddi and Kobasa talked about the transformational and regressive coping (Pestonjee, 1999). Transformational coping involves altering the stressful events to less stressful ones. This consists of interacting with the events, thinking about them optimistically, and acting towards them decisively, changing them in a less stressful direction. Regressive approach on the other hand includes a strategy where in one thinks about the events pessimistically and acts evasively to avoid contact with them.

(d) Proactive coping

While in the past coping was seen mainly as reactive - a strategy to be used once stress has been experienced, more recently, coping is being seen as something one can do before stress occurs.

Increasingly, coping is seen as having multiple positive functions. Aspinwall and Taylor (1997) opine that the idea that coping can have positive functions parallels recent research highlighting the role of positive beliefs in the promotion of health. There are three main ways in which proactive coping differs from traditional reactive conceptions of coping.

- Traditional coping forms tend to be reactive in that they mostly deal with stressful events that have already occurred with the aim of compensating for loss or harm in the past; proactive coping is more future - oriented

- Reactive coping has been regarded as risk management and proactive coping is goal management.

- The motivation for proactive coping is more positive in that it derives from perceiving situations as challenging and stimulating whereas reactive coping emanates from risk appraisal.

Proactive coping involves processes through which people anticipate potential stressors, and act in advance to the extent that individuals offset, eliminate, reduce or modify impending stressful events. Proactive events can eliminate a great deal of stress before it occurs. Aspinwall and Taylor (1997) states that the skills associated with proactive coping include planning, goal setting, organization and mental stimulation.

Next section examines many of the correlates of coping which helps to predict the nature and stability of coping across population.

Correlates of coping

Frydenberg (1997) has cited empirical and theoretical reports on the following correlates of coping.

(a) Temperament:- The role of temperament is often cited as an important determinant of coping responses by Kagan and Rutter. Temperament generally refers to an individual's stable and consistent disposition, the usual style of emotional and behavioral responses of an individual that are predictable. In the theory of temperament put forward by Buss and Plomin, three broad dimensions of personality are considered to be present in an individual's early years and continue to be relatively stable through out the life. These are emotionality, activity and sociability. It is

suggested that these dimensions may play an important role in moderating the effects of stress.

(b) Age : - There is a difference in how people cope at different stages of the life span. The growing evidence for situational and contextual determinants of coping has led to studies to determine the main changes in young people's circumstances over a two year period, and how patterns of use of coping change over that period of time.

(c) Self concept :- Self concept is one's idea and preoccupation about oneself, and is an important factor in determining behavior. Sometimes a distinction is made between self concept and self esteem. It has been proposed that high self esteem in itself is a positive coping mechanism. Seligman opined that for a long time focus has been on the enhancement of self esteem; however there is growing evidence that it may be more productive to focus on developing coping strategies and building up a flexible repertoire of coping skills that will in turn enhance self esteem.

Coping with trauma

It would be tempting to argue that the environmental pressure of trauma is so great that there are few individual differences in reaction to it. However, the trauma literature reveals marked individual difference in how people cope, although environmental factors may constrain choice.

Aldwin (1999) identified 4 ways in which the patterns of coping responses in traumatic situations differ from that in ordinary life events. First, individuals in traumatic situations may feel they have little control over their cognitions and behaviors. In naturalistic descriptions of people in traumatic situations, the number of defense mechanisms such as dissociation, repression and denial appear to be much more widespread.

Second, as observed by Lee et al., disclosure may be of particular importance in traumatic situations. Individuals who disclose to others typically do much better both in terms of short and long term outcomes. The

reaction of others may moderate this relationship. Individuals who experience negative reactions may have worse outcomes than individuals who did not disclose. The worse outcome could be attributed to the negative reactions of others.

Third, the process of coping with trauma is usually much more extended than in coping with general hassles or life events. The process of reconstructing both the life and the sense of identity may take years.

The fourth difference concerns 'making meaning'. This strategy has particular utility in traumatic situations, and may be used more in traumatic situations than with everyday stressors. Making meaning may entail reorganization of existing cognitive and motivational structures, as well as reappraisal of not only the event, but also the context of the event in a person's life.

WELLBEING

There is more to life than simply its quantity. The quality of life - how people live for as long as or as short a time they do - is equally important. Living well is sometimes referred to as wellness, and the concept cannot be defined merely by longevity or freedom from disease. It involves satisfactory relationships with family and friends, a fulfilling career, and a zest for the ongoing process of life.

Like the concepts of morale, adjustment, life satisfaction and such others which are embedded in the notions of positive mental health, concept of wellbeing is difficult to define. Wellbeing was defined by Feldman (1998), as a sense of psychological and physical robustness. Penrod (1986) defined it by identifying major indicators of wellbeing as health, marriage, family, and job satisfaction.

In the context of high quality relationships Clark and Grote (2003) defined it as each member's good physical and mental health, and each member being able to strive toward and reach desired individual and joint

goal. Sehgal (1999) reported that health and marriage were identified as the most important of the indicators while financial circumstances and involvement in the community or involvement in the professional organization was considered to be least important as the determinants of one's wellbeing. Some of the most common indicators of positive wellbeing are happiness, self esteem, optimism, and life satisfaction.

Subjective wellbeing

Subjective wellbeing is differentiated from the concept of general wellbeing. Diener, Suh and Oishi (1997) defined subjective wellbeing as to how people evaluate their lives and included variables such as life satisfaction and marital satisfaction, lack of depression and anxiety, and positive moods and emotions. Ostir et. al. (2000) opined that subjective wellbeing makes available personal resources that can be directed toward innovation and creativity in thoughts and actions. Thus subjective wellbeing like optimism becomes an antidote to learned helplessness.

Subjective wellbeing has more effect on the environment than the environment exerts on it. Vaillant (2003) studied this and found that a significant number of AIDS victims perceive that their illness has enhanced the quality of their subjective lives. Similarly, after a few weeks of temporary elation, the subjective wellbeing of the lottery winners returns to the baseline. He also opined that wellbeing is highly heritable and is relatively independent of demographic variables. He cited a study by Tellegan et al where the subjective wellbeing of monozygous twins raised apart is more similar than that of heterozygous twins raised together. He reported Diener et al's finding that among the partially heritable factors making significant contributions to a high level of subjective wellbeing are a low level of trait neuroticism, high levels of trait extraversion, absence of alcoholism and absence of major depression.

Hallmarks of subjective wellbeing

Diener, Suh and Oishi (1997) identified several cardinal characteristics in the study of subjective wellbeing, which could be briefly put into 3 groups.

First, the entire range of wellbeing extends from agony to ecstasy. It does not focus only on undesirable states such as depression or helplessness. Instead individual differences in levels of positive wellbeing are also considered important. Thus the field is concerned not just with the factors that differentiate slightly happy people from moderately happy and extremely happy people.

Second, subjective wellbeing is defined in the terms of the internal experience of the respondent. An external frame of reference is not imposed while assessing subjective wellbeing. Although many criteria of mental health are dictated from outside by researchers and practitioners (e.g. maturity, autonomy, and realism), subjective wellbeing is measured from the individual's own perspective. In the field of subjective wellbeing, a person's belief about his/her own wellbeing is of paramount importance. Naturally, this approach has both advantage and disadvantage. Although it gives ultimate authority to the respondents, it also means that subjective wellbeing cannot be a consummate definition of mental health because people may be discorded even if they are happy.

A final hallmark of subjective wellbeing focuses on long term state, not just mandatory moods. Although the person's moods are likely to fluctuate with each new event, the subjective wellbeing largely emphasizes a person's mood overtime. Often what leads to happiness at the moment may not be the same as what produces long term subjective wellbeing.

Components of subjective wellbeing

Diener et al (1999) has reported on two classifications of the components of wellbeing

(a) Affective component: - Affective component can be thought of how one feels about his/her life. There is contradictory evidence as to whether pleasant affect and unpleasant affect form two independent variables and should be measured separately or whether dependent. They further reported the findings of Diener and Emmons that unpleasant and pleasant affects become increasingly separate as the time frame is increased.

(b) Cognitive component: - Cognitive component can be viewed as how one thinks about his/her life. The cognitive component of subjective wellbeing involves making judgments of one's life. They cited Prince and Prince's suggestion that individuals judge their objective situation in each of various life domains according to standards of comparisons, personal needs and personal values. The resulting evaluation is that their satisfaction with that domain and domain of satisfaction combine to produce a general sense of wellbeing.

As cited by Sehgal (1999), Ryff put forth a model of wellbeing which includes dimensions of self acceptance, positive relations with others, sense of autonomy, environmental mastery, purpose in life and personal growth. Wellbeing is a state of physical, mental, emotional, social and spiritual wellness. Because wellness is continuous and dynamic, no dimension of wellness functions in isolation. Dimensions of wellness are:-

- Emotional wellness which requires understanding emotions and coping with problems that arise in everyday life.
- Intellectual wellness which involves having mind open to new ideas and concepts. If one is intellectually healthy, he seeks new experiences and challenges.
- Spiritual wellness which is the state of harmony with yourself and others. It is the ability to balance inner needs with the demands of rest of the world.

- Occupational wellness is being able to enjoy what you are doing to earn a living and/or contribute to the society. In a job it means having skills such as critical thinking, problem solving and communicating well.

- Social wellness refers to the ability to perform social roles effectively, comfortably and without harming others.

- Physical wellness is a healthy body maintained by eating right; exercising regularly, avoiding harmful habits, making informal and responsible decisions about health, seeking medical care and participating in activities that help prevent diseases.

Determinants of subjective wellbeing

Although many goals are idiosyncratic, the ability to control one's life seems to be highly valued. Mastery over one's life represents a key concern in some assessments of quality of life. Weston (1999) referred to studies which indicate sense of mastery (or self efficacy, locus of control, confidence) is frequently treated as a more or less stable personality disposition or generalized belief or outlook on life that affects appraisal of circumstances, stress, wellbeing, coping behavior and so on. In addition to sense of mastery, matter pertaining to financial resources, work (paid or unpaid) and family life is likely to feature strongly in personal commitments that affect wellbeing. Occupational status as having implications for mastery over one's work role, and mastery increasing with increasing status are also cited. Studies also show the importance of employment and occupational status on wellbeing.

Weston (1999) also stated that family is the key unit in one society through which our basic needs are met. Research consistently suggests that subjective wellbeing is strongly affected by the quality of marital relationships and family life. Weston also inferred that a strong positive relationship not only implies that those who are happy with family life tend to be happy with

life in general, but that pervasive discontent is likely to coexist with unhappy marriage or family life.

Diener, Suh and Oishi (1997) posited that subjective wellbeing is gained when goals and needs are reached. They cited Emmons that, individuals high in subjective wellbeing perceived their goals as more important and as higher in their probability of success, whereas those low in subjective wellbeing perceived more conflict between their goals. Diener et al cited the proposal of Veenhoven that aims related to universal human needs are those that produce long term subjective well being. According to this approach people cannot be happy when experiencing chronic hunger, danger or isolation. They further cited Ryan et al that goals that meet intrinsic needs such as autonomy, relatedness and competence are hypothesized to predict subjective wellbeing, whereas goals reflecting extrinsic needs are hypothesized to be negative predictors of well being.

Diener et al argued that subjective wellbeing is also related to one's values. If an individual's subjective wellbeing are congruent with his/her values, subjective wellbeing becomes a broader measure of quality of life because it reflects deeper values beyond physical pleasure and ephemeral emotions. It appears that people's subjective wellbeing is to some degree related to their fulfillment of their values.

Mental health as a dimension of wellbeing

The origin of the word health in English language relate to wellness and 'wholeness'. From this perspective, health concerns physical, mental, spiritual, and social wellbeing. Mental health is a contested term - definitions of mental health vary significantly from culture to culture and may vary from person to person. Mental health can be defined as a person's potential to learn how to communicate and how to do things; express himself/herself both emotionally and intellectually; feel at ease and have a sense of autonomy to cope with change and uncertainty; and form and maintain relationships with other people (Scottish Public Mental Health Alliance,

2002). Mental health can also be defined as a state of emotional and social wellbeing in which the individual realizes his/her own abilities, can cope with the normal stresses of life , can work productively or fruitfully, and is able to make a contribution to his or her community (WHO, 1998).

These attributes enable a person to interact with the natural and social world in a way that supports their survival and wellbeing throughout the life. In addition to these, the qualities of self esteem and empathy for others are critical for mental health and wellbeing. Positive mental health does not involve just being a joy to others; one must also experience subjective wellbeing. The mental health issues involved in subjective wellbeing are complicated and clouded by historical relativism, value judgments and illusions. On the one hand, happiness that comes from joy or unselfish love, that comes from self control and self efficacy, or that comes from play or deep or effortless involvement reflects health. On the other hand happiness can be based on illusion or on dissociative states and the search for happiness can appear selfish, narcissistic, superficial and banal (Vaillant, 2003).

Mental health and wellbeing are qualities which are not possessed by individuals, but which are created through dynamic interaction between their mind, body and environment. Moreover mind and body are intimately linked and mutually dependent. Mental health is fundamental as it affects bodily functions.

MENTAL HEALTH OF WOMEN

Gender differences related to various dimensions of behavior has been one of the areas of interest to researchers. As in mental health such differences have been discussed mostly in terms of physical or psychological (body-and-mind) attributes. Of late with the emergence of feminist tradition, focus has also been extended to the socio- political-cultural environment. So it is imperative to look at mental health of women as distinct from that of men.

According to Thara and Patel (2001), the state of women's mental is indeed in a state of flux. On the one hand it has begun to figure as never before on the agenda of many national and international commissions and organizations. On the other hand, reports of violence against women are on the increase - violence of a nature that scars the psyche almost permanently and even affects the social position of women adversely. Childhood sexual abuse, female infanticide, battering of female children, the resulting homelessness and psychological trauma inflicted by dowry demands are all sordid tales of world's apathy, neglect and indifference to women's woes. The relative lack of education and authority makes them extremely vulnerable to all kinds of abuse, all of which results in increasing emotional morbidity. This inextricable inter- twining of the state of education, economy, autonomy and health makes it imperative that a multi-pronged strategy be deployed to address women's mental health problems systematically

The problem of mental health of women occurs at three levels. Firstly, a large amount of mental disorders among women remains unrecognized and untreated. Secondly there are number of mental disorders which are disproportionately more among them. Thirdly, due to social and gender inequity, women receive less than their proper share of benefits of mental health services in a poor country like India (WHO, 1998). Mental health, mental health problems and mental disorders result from complex combinations of factors - biological, psychological, social and structural. Opportunities for people to exercise control over their lives and set goals, to use their skills, to have a range of experiences and to engage in supportive social interactions are important to mental health. Having a sense of being valued for what one does, an adequate income and physical security are also fundamental.

Psychosocial determinants of women's mental health

Women's mental health is closely intertwined with many other facets of her life. Of many psychosocial factors, the important ones have a definite

impact on women and their lives are gender, multiple roles, marriage and their reactions to stress.

(a) Gender Roles

The power of gender roles to influence behavior derives not only from their description of typical and desirable behavior but also from their tendency to be relatively consensual and for people to be aware of this consensus. The ability of gender roles like other social roles to produce role consistent behavior follows from the overall validity of the assumption that most other people hold these expectations (Eagly, 2000). People thus believe that the typical other person holds these beliefs and would react approvingly to role consistent behavior and disapprovingly to inconsistent behavior. Therefore the most likely rote to social approval in most situations and a smoothly functioning social interaction is to behave consistently with one's gender role, or at least avoid strongly deviating from this role. Because the societal expectations are more on women's gender role, often it pressurizes her and pushes her to a corner, where she is left with no choice.

Gross (1997) cites Tavris that the view that man is the norm and women is the opposite, lesser or deficient one of the three currently competing views regarding to what she calls the 'mismeasure of women'. This is the view which underlies so much psychological research designed to discover why women are not as something (moral, intelligent, rational) as men. Gross further cites a study by Broverman et al who asked several psychiatrists to define a healthy adult, healthy adult male and healthy adult female. Responses regarding the first two were very similar, the character defined by traits such as assertiveness, aggression, ambition and task oriented. But healthy women were viewed as caring, expressive, nurturing, and affiliative. Women therefore are in a double bind. As healthy women, they fall outside the norm for healthy adults; if they assume male characteristics, they step outside the definition of a healthy woman.

In this context, it is also relevant that possessing a female physiology often brings about a number of problems. Problems related to physiological changes like premenstrual depression, menstruation it self with physical discomforts and cultural/religious taboos, premenopausal syndrome and menopause demand mental resilience and flexibility by the women. There are mental health issues which are exclusively related to pregnancy and post partum period like post partum depression, puerperal psychosis, and stresses of caring for a newborn infant (Eagly,2000).

(b) Marriage

In India and elsewhere, marriage is the basis of social life and is a matter of great importance (Rao and Rao, 1999). Reidman and Lamana (2003) have extensively reported on this relation. A husband has been culturally and legally expected to be his family's principal breadwinner. Wives are culturally and legally bound to husband care, house care and child care. So according to the traditional exchange model, the male exchanged breadwinning for the female's homemaking, child rearing, sexual availability, more general husband care and emotional support. Though wives are traditionally deemed as homemakers, families and societies at large tend to ignore the economic benefits to society provided by homemaker along with her other contributions. The work that is directly productive is more highly valued and rewarded in most societies. Therefore it is not surprising to find that the job of homemaker has ambiguous status and low economic rewards. Bird and Ross opines that an essential feature of the housewife role is the constant availability to meet others' needs, and female house workers report a lower sense of being in control of their lives than do women employed otherwise.

Reidman and Lamana further cites Glass and Fujimoto that the more time that is spend in housework, the more the appearance of depressive symptomatology in both men and women. Klein et al says that the critical difference between fulltime home makers who enjoy their work and those

who don't is a choice. Satisfied homemakers are women who are exercising their preference to work in the home.

Duffy and Atwater (2002) reported the findings of Baruck, Biener, and Barnett that women who are home makers face many if not more, of the stressors than women who work outside the home. The roles of wife and mother are often conflicting. There is a lack of structure and reward for many of the jobs faced by a homemaker. In addition, being isolated at home gives one few opportunities to develop social relationships and networks.

In the context of marriage, while coping, women consider the impact of their behavior on other people - especially spouse and children - and take into account their opinions and feel comfortable asking for others' help and reciprocating. The resulting support or lack of it significantly affects the sense of wellbeing of the female spouse and interpersonal relationships (Belchman, 2000).

Marital problems often precede the onset of individual problems like excessive drinking and depression and correlate with several health problems, including suppression of the immune system (Markham, Halford,and Lindhal,2000). Distressed couples are highly emotionally reactive to their partners' negative behavior and show significantly higher rates of negative reciprocity during interactions than do satisfied couples. In addition to negative reciprocity, relationship distress is also associated with high levels of psycho-physiological arousal during interactions. Such arousal is assumed to be aversive and may explain the higher rates of withdrawal during problem- focused discussions by distressed partners. Both the extent of arousal and the frequency of withdrawal prospectively predict deterioration in marital satisfaction.

(c) Multiple roles and its impact on women's sense of well being and mental health

Society places unique demands on women to find a balance between meeting the role expectations of an employee earning an income to support their family and pursuing a career on the one hand, and juggling with the social roles of being a wife, mother, caretaker and supportive friend on the other. Geller, Graf and Dyson-Washington (2003) cites Goode, Marks and Seiber on two primary theories that serve as a basis for a great majority of the research examining multiple roles. The *scarcity hypothesis* suggests that the more roles occupied by a woman, the more likely she is to deplete her limited resources resulting in negative consequences for her health and wellbeing. The *enhancement hypothesis* suggests that multiple roles result in greater access to resources and increased likelihood for role balance.

Women's role as caregiver, both lay and professional, has been a primary focus in the research examining multiple roles, because the caregiving role is held by the majority of women (Geller, Graf and Dyson-Washington, 2003). Multiple roles do not merely imply juggling work and household tasks, because women are also the predominant caregivers and support providers to elderly parents, in-laws, children, husband and other family members. Preston and Walker et al categorized these women with additional role into 'sandwich generation'. Such women are at increased risk for health problems as they experience the stress and time constraint of providing care to elderly friends, parents or other family members while simultaneously providing care to their own children, supporting their partners and functioning as employees in the work place. Further Yee and Schulz found that female caregivers tended to report higher rates of depression and anxiety and lower levels of life satisfaction than male caregivers. Geller, Graf and Dyson-Washington (2003) have attempted to investigate different factors that may increase a woman's risk for role overload or serve as a buffer for experiencing distress related to multiple roles. They cited the

findings of Marshall and Barnett that a major factor, namely, social support from family and friends, appears to limit women's struggle with finding a healthy balance between work and family life, and enhance the benefits of multiple roles, involves social support from family and friends. Further, Marks suggested that role commitment is a second factor that may increase women's distress when dealing with multiple roles.

For the majority of the women, the role of mother and house wife is ill-defined as well as insufficient. Being a housewife means little more than adjusting to day-to-day events which in the long term are trivial but which appear important at that time (Frost, 1977). However, one important part of the background that must not be overlooked is that working women have an additional stress to contend with - that of working many more hours per day than men do, since their jobs are usually in addition to keeping the house running smoothly.

(d) Reactions to stress in women

Considerable research has revealed that women experience and respond to stress in distinctive ways compared to men (Helgeson, 2006). Women's stress response process is both qualitatively and quantitatively different in terms of hormonal profile, activation of the sympathetic, adrenal, medullary, and hypothalamic - pituitary-adrenal-cortical response pathways, and in emotional quality. Their typical stress response is also attenuated by the phases of the menstrual cycle related to the synergestic effects of the ovarian steroids. In addition, the nature of women's lives and realities render them at risk for stress related effects more than men. Only, perhaps, do single fathers with dependent children approach the sheer level of multiple responsibilities that majority of women carry.

Although women often report more distress and bodily symptoms than men, it should not be concluded that women generally lack appropriate coping skills. Since the vast majority of research relies on self report scales, it is pre supposed that women have a greater tendency to admit symptoms

such as pain, depression or negative mood (Geller, Graf and Dyson-Washington, 2003). Another factor that has to be taken into account is the social support system. The perception, availability and activation of social support are major factors in successfully dealing with stress. Greenglass, Hobfall and Simon opined that women tend to have larger and tighter networks that enable them to seek support from many sources, whereas men often solely rely on their spouses as support providers. Differences between men and women are primarily mediated by the social support they seek and receive (Geller, Graf, and Dyson-Washington, 2003)

It is important that we have an understanding of what it takes to undergo the stress and strain of caring for the mentally ill in the family especially when it comes to the woman of the family as primary caregiver.

CARING FOR MENTALLY ILL IN THE FAMILY

Mental illness weaves a web of doubt, confusion and chaos around the family. Unwittingly the person with mental illness can dominate the entire family through control, fear or helplessness and incapacity. Like a bully, the mental illness bosses the primary sufferer as well as the loved ones. Instability, separation, divorce, and abandonment are frequent family outcomes of mental illness.

Families are an integral part of the care system for persons with mental illnesses, be the nature of mental illness is chronic as in schizophrenia, or is as of intermittent frequencies as in affective disorder, opined Vaddadi,(1997). He pointed out that the demands of being involved in the case of a seriously mentally ill relative have both an emotional and practical impact on the caregiver. He cited the definition by Grad and Sainsbury, Pai and Kapur, and Schene et al (2005) that family burden is the cost that families incur in terms of economic hardships, social isolation and psychological strain.

Studies that examine the relationship between the severity of disability (psychotic and functional) and caregiver burden, variables have been categorized as patient variables, namely extent of disability, age and length of illnesses, and caregiver variables such as perceived burden, age and relationship to patient (Bhatia, Tucker and Kapoor,2003). The two categories described by them are as follows:-

(a) Patient variables and stress on the caregiver

Disability is defined as any restriction in ability to perform an activity in a manner or within the range considered normal for a human being. The psychotic disability can be viewed in terms of the extent of psychopathology present in the patient and the functional disability can be viewed in terms of the patient's level of functioning in the domain of daily activities, self-concern, social and occupational functioning.

With respect to the age of afflicted person, it is actually critical because this determines the likelihood of a person having completed the necessary developmental stages to adulthood. An individual's educational and skill levels and social competencies are highly relevant to his/her capacity for independent living.

Length of illness is a major variable that interferes with normal life cycle among persons with severe mental illness. Among individuals who have been able to fulfill social roles at particular times in the life cycle, a chronic mental illness adds to the strain when these roles later become unavailable. Societal stigma adds to the totality of the strain experienced. They have cited Campbell's report that this is manifested in multiple ways ranging from loss of friends to open discrimination in employment, housing, and insurance.

(b) Caregiver variables as stressors

Bhatia, Tucker, and Kapur referred to Grad and Sainsbury that burden is conceptualized as any costs to the family. The most recent investigations

make a distinction between those that could be observed objectively and those that are subjectively experienced such as overload and resentment. They added the report by Rabins et al that the severity of symptoms might have an impact on the perceived burden of some caregivers.

Caregiving stress also varies as a function of physical energy and other role demands concordant with the caregivers' age or a particular stage in his/ her life cycle. Bhatia, Tucker and Kapur (2003) also cited Gopinath and Chaturvedi that the caregivers who are younger and more educated experience greater burden. Closer the relationship of the carer with the patient, higher the levels of feelings of helplessness and guilt over not able to do enough for the patient.

Caregiving as a stressor

Being a 'frontline' carer for someone with mental illness can create considerable costs for families and often involves the family unit in long term stress that threatens the physical, social, and mental wellbeing of all family members. Carers are often thrown into deep end with little or no formal training in handling mental illness. Carers often face a lack of information about the disorder and its medication, a lack of resources, treatment facilities and at times a lack of responsive professionals.

Care giving is a chronic stressor, and different coping methods are used to handle such a situation. The use of coping strategies such as avoidance, denial, and resignation as pointed out by Budd et al (1998), is linked to greater burden. The 1999 National Survey of Carer Health and Wellbeing indicated that the stress of earning, social isolation, and loneliness changes relationships and a sense of grief or loss were major factors for carers feeling sad, depressed, worried and/or anxious. Carers also reported tiredness or exhaustion related to the constant pressure of caring, stress, inadequate free time or rest, and lost sleep (Carers' Association of Australia, 1999).

The relationship of the primary caregiver and the patient may also mediate the experience of burden. Spouses of caregivers experience difficulty in terms of having to balance multiple roles, raising children and bearing with financial burden, particularly when the illness strike the primary wage earner, as found by Mannion et. al, (1996).

Utilization of social support and a sense of mastery over the situation are associated with lower levels of burden and distress. As observed by Budd et al (1998), greater use of problem solving as a coping strategy and less use of denial, is a predictor of wellbeing in the family caregivers.

BURDEN OF CARE

Bhatia, Tucker, and Kapur (2003) cited Hamilton and Hoening on their attempt to distinguish between objective and subjective burden. The former includes the effects of the illness on finances and routine of the family, while the latter is defined as the extent to which family members are affected by the stressor.

Objective burden in caring of the mentally ill

Amongst the objective burdens, financial burden is considered to be of the primary one. The carer is often subjected to financial and employment difficulties, as well as loss of opportunities and potentials. Besides economical strain, the carer also suffers from impaired physical health as reaction to the ongoing stressor. Another cost of caring is the disruption of relationships. Family relationships can suffer because the sick relative's behavior can be extremely difficult to cope with and symptoms can be disruptive. The problem of disrupted relationship is compounded by reduced social networks. This is due to the disruption of normal social and leisure activities as well as to the stigmatization that often occurs hand-in-hand with a diagnosis of mental illness (WHO, 1998))

Subjective burden in the caring of the mentally ill

Subjective burden experienced by caring family has been directly linked to the experience of objective problems (Awad and Voruganti, 2008). Subjective burdens are more emotional in nature and include feelings of anxiety, stress, guilt, shame, self blame, depression, fear, anger, and confusion. Caring for someone with mental illness can be both time and energy consuming. Family and friends are often relegated to second place, and the carer's own plans and ambitions are more often than not put on hold, which can lead to feelings of anger and resentment. Grief is also a very common reaction in the carers. It is often manifested as the adjustment of coming into terms with the disintegration of the personality of the family member as in schizophrenia, or disturbance manifested as in the manic and depressive phases of affective and brief reactive psychosis. Other experiences include lowered self esteem, increased isolation, and withdrawal due to stigma and reduced social network.

COST OF CARE TAKING

Five factors are identified which play a crucial part in the family dynamics (Bhatia, Tucker, and Kapur, 2003).

Stress

Stress is at the foundation of the family experience of mental illness. There is constant tension, worry, and dread because the illness can strike any time. The stress accumulates and frequently leads to psychosomatic illness.

Trauma

Trauma also lies at the core of family's experience. It can erode family's beliefs about control, safety, meaning, and their own values. Another form of trauma is 'witness trauma' where the family watches helplessly as the loved ones are tortured by their symptoms. This type of family atmosphere can often induce the development of traumatic symptoms like invasive thoughts, distancing and physical disorders. The result can be traumatic stress or post traumatic stress disorder. Much of the family's despair results from trying to manage and control what it cannot.

Loss

Family members report losses in their personal, social, economical, and spiritual lives. They suffer loses in privacy, freedom, security and sometimes even in dignity. The family maybe is the only place where one cannot be replaced. So it can be devastating if one cannot have effective family relationships.

Grief

Grief occurs from loss. Family members can go through protracted grieving which often goes undiagnosed or untreated. Grieving centers around what life will not be. Grieving can become compounded because our culture does not sufficiently acknowledge and legitimize the grief of those under the influence of mental illness. Mourning fails to occur due to the perception of the caregiver that he has no right to feel bad. Thus acceptance and integration of loss is prevented.

Exhaustion

Exhaustion is the natural result of living in such an atmosphere. The family becomes an endless expenditure - emotional and monetary resources, and must frequently monitor the concerns, issues and problems

of the ill. Worry, preoccupation, anxiety and depression can leave the family drained - emotionally, physically, spiritually and economically.

Living in an environment of chronic stress, trauma, loss, grief, and fatigue can also lead other family members to their own parallel disorders. Parallel disorders of family members are also known as secondary or vicarious traumatization (Awad and Voruganti, 2008). Family members, especially the primary caretaker can develop symptoms including denial, minimization, high tolerance of inappropriate behavior, confusion and doubt, guilt and depression and other physical and emotional problems. Other more recent terms include learned helplessness which occur when family members find that their actions are futile, depression fallout - the consequences of living in close proximity to a loved one's despair, and burnout that comes from the intimate relationship when family members believe they cannot help their loved ones and are unable to disengage from the illness long enough to get restored (Awad and Voruganti, 2008).

BURDEN OF CARE WITH AFFECTIVE DISORDER AND SCHIZOPHRENIA

Dealing with a loved one who is suffering from mental illness is similar to coping with an elderly parent or child who has an unremitting physical ailment (Nemecek, 2004). Providing care while trying to function in other facets of life - work, children, house hold demands etc. - is exhausting. Add to it the internal turmoil that family caregiver suffer - a sense of loss over the end of a relationship as you once knew it, the feeling of responsibility that only you can provide, coming into terms with the stigma surrounding the mental illness, a sense of guilt that perhaps somehow, you caused the stress that led to mental illness - and the experience can be overwhelming.

Along with the advent of antidepressants and antipsychotic drugs in 1950s, advances in psychotherapy, and changes in the commitment laws, there occurred an emphasis on deinstitutionalization as well. Deinstitutionalization is the removal of the patients from the mental hospital to give them the least restrictive care as possible (Kalat, 1999). This places

the onus of care on the family. The more chronic the disease, the more stressful it can be for family members to provide care.

Bipolar disorder which is distinguished by extreme mood changes from mania to depression can be especially difficult to manage. Mood changes can last anywhere from hours to months. Not only must family caregivers manage a bipolar patient's wide swing between mania and depression, they also often feel compelled to 'fix' problems the loved one causes during acute mood swings. In this context it is relevant to note that there is increasing evidence that the affective quality of the family environment predicts the short term course of a major affective disorder (Goldstein, 1988).

During manic phase, individuals may have very poor judgment and do things they would otherwise not do - spend or gamble significant amounts of money, give away prized family possessions or engage in risky sexual behaviors (Sadock and Sadock, 2003). As family members deal with such occurrences again and again, they can easily become overwhelmed to the point where they simply cannot function (Nemecek , 2004).

Depressive phase of the bipolar affective disorder also taxes the family, as the patient slips into depression, accompanying inactivity and social withdrawal, and runs the risk of suicide (Sadock and Sadock, 2003). The family is required to be vigilant in case the patient attempts to take his/her own life. They also need to cope with the 'temporary' absence of the patient from his/her usual familial, social and at times occupational circles (Nemecek, 2004).

Schizophrenia - the most chronic and disabling of severe mental illnesses takes a substantial emotional toll on the family caregivers (Hammen, 2003). Symptoms of this disease usually appear in young people in their teens or early twenties, and are confusing and often shocking to families. Although patients receive treatment, the natural course of the

illness generally results in an ever increasing debilitation in subtle aspects of emotions at least. This can be devastating for relatives longing for recovery.

PRESENT STUDY

Health or illness has always remained an area of concern for human beings. All systems of treatment emerged as a result of the attempts to attain control or to manage one's body or bodily mechanisms. The 'patient' or the 'diseased' sought all the attention for the past few centuries. However in the recent years the concept of caregiving and 'caregiver' has come to the fore. Along with these concepts, the psychosocial dimensions of caregiving and the needs of the caregiver gained emphasis. Studies available in this area are mostly related to terminal illnesses like cancer, coronary heart disease etc.

As deinstitutionalization is being emphasized, and the notion of treating and rehabilitating mental patient in the home environment catches on in the mental health field, we see more and more patients at their homes itself as contrasted with the scenario of past 2 decades.

When a spouse is mentally ill, instead of disintegrating, the ideal thing to happen in a family is re-organization (Graf, Geller, Dyson- Washington, 2003). Family re-organization would involve its reshaping through the redefining of attitudes and values of members - the husband and wife, the parents and children - and in the development of a new conception of the family which its members individually and collectively realize.

Keeping this background in mind, it is imperative that the mentally ill person finds himself in an atmosphere that is congenial for his recovery and rehabilitation. For this purpose it is essential that his/her spouse be able to handle the situation properly, no matter how taxing and demanding the situation is. As in many other spheres of life, the impact of mental health problems also show a gender differential (Thara and Patel, 2001). It has been found that whereas women are required to be the primary carers if their

husbands become mentally ill, it was the woman's own families that are responsible for their care if they were to become ill. So in many instances when compared to husbands, it is the wives who are the primary carers. To exercise this additional caretaker responsibility properly, the wife should be mentally healthy.

Women are integral to all aspects of society. However the multiple roles that they fulfill 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, mothers, and carers. Increasingly women are becoming an essential part of the labor force too which adds to her burden. In addition to the many pressures placed on women, they must contend with significant gender discrimination and the associated factors of poverty, hunger, malnutrition, and overwork. These forms of socio-cultural violence contribute to the high prevalence of mental health problems experienced by women.

It has been observed that women suffer from relationship stresses more than men do. They are more vulnerable to partnership and marital dissatisfaction (Csoboth, 2003). In the light of this observation, it is quite logical to deduce that when her spouse falls victim to mental illness, the wife suffers as much or sometimes more than the victim does .As observed by Vangelisti and Alexander (2002) distressed couples are highly reactive emotionally to their partners' negative behavior and show significantly higher rates of reciprocity during interactions than do highly satisfied couples. Mental illness in the family calls in for the interplay of negative reciprocity. Having a spouse with mental illness is one instance where the relational standard goes unmet. This unmet relational standard can cause a gamut of emotions ranging from anger and resentment to guilt and self pity.

When a spouse falls mentally ill among many of its implications and consequences is the sense of loss of control over the situation. Although many goals are idiosyncratic, the ability to control one's life seems to be

highly valued by most people. Mastery over one's life represents a key concern in some assessments of quality of life (Weston, 1999). The perception of the situation as one over which the individual has no control, however temporarily can be a cause of stress for the spouses involved. For a female spouse, this observation holds true. As is common in our culture and in cultures elsewhere, it is an undeniable fact that a female after her marriage loses much of her original social support system (Davar, 2003).This diminished social support also can contribute the stress as well as affect the coping behavior. Another factor that works against women in coping is ruminating over stressful events, which is found more in females than in males (Csoboth,2003). Whereas men usually distract themselves from the stressful situation, women do not employ this coping behavior. Ruminating can often result in poor quality of life and subjective distress.

It has been found that female caregivers tended to report higher rates of depression and anxiety, and lower levels of life satisfaction than male caregivers. Increased rates of depression and anxiety were found in female caregivers when compared to the female non-caregivers in the community (Geller, Graf, Dyson-Washington, 2003). Also it has been found that there are significant increases in psychological distress as women adjust to the caregiver role, as well as in women who are continuing to provide care. All this distress can no doubt negatively affect the well being of women. When the care is suffered, it results in poor prognosis for the patient, because of the interplay of high levels of expressed emotions and deteriorating interpersonal relations.

Cultural expectations and demands also take their toll on women. Normative ideas on mental health have been constructed on the ' male as normal' model (Davar, 2003). By implication, women, their cognitive and emotional lives, their 'life worlds' and femininity in general has been seen as definitively psychopathological. Various aspects of women's lives are culturally endowed with significances, not always in women's interests.

Cross cultural paradigms and cultural understandings of human behavior have addressed the issue of modernity with out compromising on the cultural imperative of conformity for women to stipulated social areas (Davar, 2003).

The necessary tasks of attending to both the emotional needs of all family members and the practical needs of the dependent members such as children or elderly parents, as well as maintaining the family domicile are often executed by women. Our cultural tradition and social institutions give women principal responsibility of raising children. More over, our culture designates women as 'kin-keepers', whose job is to keep in touch-and if necessary, care for adult siblings and relatives. In this sense, women are often the teachers and preservers of culture, tradition, and value systems. It is through them their children get to know the world and significant others, and equips themselves with necessary skills for meeting stresses and challenges. This point makes the well being of the women even more relevant. The demands made on women and expectations of them become manifold when their spouses are mentally handicapped. Then, it is only predictable that women, as they have to wear many hats at a time and juggle roles which are exacting come under tremendous pressure. More over, when her husband who is bound to extend his support in trying times become unavailable due to a mental illness, that unavailability itself acts as a stressor with tremendous impact over her sense of well being. Therefore the present study tries to explore the relationship between the stress tolerance, coping styles and well being of women whose husbands are mentally ill.

OBJECTIVES OF THE STUDY

a) To study the stress tolerance of the women whose husbands are mentally ill.

b) To study the coping styles of the women whose husbands are mentally ill.

c) To study the well being of women whose husbands are mentally ill.

d) To study the relationships between stress tolerance, coping styles and well being of the women whose husbands are mentally ill.

Following hypotheses were formulated as a framework for the study:

1. Women whose husbands are mentally ill differ from husbands whose wives are mentally ill in terms of stress tolerance.
2. Women whose husbands are mentally ill differ from husbands whose wives are mentally ill in terms of well being.
3. Women whose husbands are mentally ill differ from husbands whose wives are mentally ill in terms of coping styles.
4. Stress tolerance and well being are related in the spouses of mentally ill.
   a) Stress tolerance and wellbeing are related in the female spouses.
   b) Stress tolerance and wellbeing are related in the male spouses.
5. Coping styles and well being are related in the spouses of mentally ill.
   a) Coping styles and wellbeing are related in the female spouses.
   b) Coping styles and wellbeing are related in the male spouses.
6. Coping styles and stress tolerance predict wellbeing in both the genders whose spouses are mentally ill.
   a) Different coping styles and stress tolerance can be used to predict the wellbeing in the female spouses.
   b) Different coping styles and stress tolerance can be used to predict the wellbeing in the male spouses.
7. Coping styles and wellbeing predict stress tolerance in both the genders whose spouses are mentally ill.
   a). Different coping styles and wellbeing can be used to predict the stress tolerance in the female spouses of the mentally ill.
   b). Different coping styles and wellbeing can be used to predict the stress tolerance in the male spouses of the mentally ill.

REVIEW OF LITERATURE

Sandhya. C. “Stress tolerance, coping styles and well-being of women spouses of mentally ill” Thesis. Department of Psychology , University of Calicut, 2008

Chapter 2

Review of Literature

- Stress, Stressors and Stress tolerance
- Coping and adjustments
- Gender differences on stress coping and related aspects
- Mental health and related issues
- Wellbeing
- Burden of care

Literature review refers to any collection of materials on a topic, not necessarily the Great Literary Texts of the World. A literature review discusses published information in a particular subject area, and sometimes, information in a particular subject area within a certain time period. It might give a new interpretation of old material or combine new with old interpretations. Or it might trace the intellectual progression of the field, including major debates. It provides the investigator with a handy guide to a particular topic. Literature review demonstrates that the researcher knows the field, justifies the reason for the research and allows the researcher to establish her/his theoretical framework and methodological focus. The literature review is commonly seen as the springboard to the thesis.

Review of literature was done extensively under six headings, namely, (a) stress, stressors and stress tolerance, (b) coping and adjustment, (c) gender differences on stress, coping and related aspects, (d) mental health and related issues, (e) wellbeing, and (f) burden of care. Although literature on these is quite vast, mostly studies reported since 2000 are only cited in this chapter.

STRESS, STRESSORS AND STRESS TOLERANCE

Empirical literature on stress is often categorized into three –stress, stressors and stress tolerance

Olley, Brieger and Olley (1997) studied the perceived stress factors and coping mechanisms among mothers of children with sickle cell disease

in Western Nigeria. A sample of 200 mothers attending 6 SCD clinics in both private and in public hospitals in the Ibadan-Ibrapa Health Zone of Oyo state, Nigeria, were interviewed. Stress levels were measured using an instrument comprised of stressors listed by mothers themselves in focus group discussions that preceded the survey. Higher levels of stress were associated with less educated and older women, as well as non married women and those in polygamous households. Stress levels were also greater when there was more than one child with SCD in the family and when the index child was of school age. Coping mechanisms varied according to the category of the stressor. Financial stress and disease factors were met with confrontation, while family source of stress were complained about, accepted, or avoided. Knowledge of the different types of mothers who experience more stress and of their preferred coping mechanisms can be useful in designing clinic based counseling.

Nightingale and Williams (2000) studied attitudes to emotional expression and personality in predicting post traumatic stress disorder. The objective of the study was to test hypothesis derived from a suggestion of Williams (1989) that negative attitudes toward emotional expression act as a predisposing or maintaining factor for post traumatic stress reactions following a traumatic event. The study employed a prospective design in which attitudes to emotional expression, the 'Big Five' personality factors (Costa and McCrae,1992) and initial symptoms and injury severity in one week of a road traffic accident were used to predict the development of post traumatic stress disorder 10 weeks post accident. Sixty victims of road traffic accidents were randomly selected and assessed by questionnaire and interview. Measures comprised a 4 item scale relating to emotional expression, standardized scale for intrusion and avoidance features of traumatic experiences and for anxiety and depression and the NEO FI 5 factor personality inventory. Forty five of the participants responded to the postal questionnaire follow up. This also included a self report diagnostic measure of PTSD. A small but significant relationship was found for negative

attitudes to emotional expression at one week to predict intensive symptoms, and diagnosis at 6 weeks, over and above the independent relationship of initial symptoms, initial injury severity, personality and coping. The emotional expression measure was largely stable between the two points of measurement. More negative attitudes were related to less openness and agreeableness personality domain.

Jain, Chopra and Nalwa (2000) conducted the study whose aim was to examine the magnitude of stressful events, psychological distress and coping behavior of angina patients and normal controls. The subjects were randomly drawn from a patient population by a qualified cardiologist after clinical investigations. The normal controls matched for age and education was drawn from the general population on the basis of a screening test. The results of the study employing 45 angina patients and 35 normal controls revealed that stress score of life events and psychological distress of angina patients were significantly higher than normal controls. Even though there was no significant difference in their coping behavior. Angina patients showed more use of Avoidance positive approach and Avoidance negative approach and less of Active cognitive approach when faced with stressful situations.

Koopman et al (2000) examined the relationships of coping, attachment style and perceived social support to perceived stress within a sample of HIV positive persons. Participants were 147 HIV persons (80 men and 67 women). Multiple regression analysis was used to examine the relationship of the demographic variables, AIDS status, three coping styles, three attachment styles and perceived quality of general social support with total score on Perceived Stress Scale (PSS). PSS score was significantly associated with less income, greater use of behavioral and emotional disengagement in coping with HIV/AIDS and less secure and more anxious attachment styles. These results indicate that HIV positive persons who experience the greatest stress in their daily lives are those with lower

incomes, those who disengage behaviorally and emotionally in coping with their illness, and those who approach their interpersonal relationships in a less secure or more anxious style.

Hatter- Pollara, Meleis, and Nagib (2003) studied the multiple role stress and patterns of coping of Egyptian women. In the study reported here, 190 women in Egypt employed in clerical jobs were asked about the satisfaction and stress they experience in their work and maternal roles. They were also asked about their coping approaches and the demands in their daily lives. The Women's Role Interview Protocol was used to collect data. The results were analyzed within the symbolism of the Arab/Egyptian language using thematic and content analysis. A prevailing theme is the interconnectedness among all women's roles when describing their stress, satisfaction, and coping. Another major theme that transcends all roles is the perception of inequality and how it affects their daily lives. Emergent stressors were grouped under employment role stress, maternal role stress, marital role stress, and relational role stress. Women coped through learning to be self-reliant and by using cognitive and emotion-focused coping approaches. Women's stress was embedded in inequality in gender roles, and the women are empowered to cope through relying on endurance and outliving conflict.

Park and Fenster (2004) examined the process through which stress related growth may occur and the relationship of this growth to adjustment over time. Ninety four students completed measures of personal resources and adjustment. Six months later, they completed a second set of measures that also included questions about their most stressful experience in the past 6 months as well as cognitive processing, coping and growth related to the stressor. Results suggested that specific coping processes (resources, appraisals, and coping activities) and to a lesser extent cognitive processing, were related to growth. Stress related growth predicted increases in personal

resources and positive states of mind, but was unrelated to depressive symptoms.

Abela, Brozina and Seligman (2004) tested the integration of the diathesis-stress component of the hopelessness theory of depression (Abramson, Metalsky, and Alloy, 1989) and Person's and Miranda's (1992) activation hypothesis (depressiogenic inferential styles are typically latent cognitive processes that must be primed in order to be accurately assessed). To test the diathesis-stress component of the hopelessness theory, authors used a short term longitudinal design. To test the activation hypothesis, inferential styles were assessed both before and after a negative cognitive priming questionnaire. A group of 165 university students completed measures of inferential styles about the self, the consequences, and causes before and after completing a negative priming questionnaire (Time 1). Participants also completed measures of depressive symptoms prior to completing the cognitive priming questionnaire and 5 weeks later (Time 2). Finally negative events occurring between Time 1 and Time 2 were assessed. Contrary to the diathesis-stress component of the hopelessness theory, none of the unprimed inferential styles interacted with negative events to predict increases in depressive symptoms. In line with the integration of the hopelessness theory and the activation hypothesis, however, each of the primed inferential styles. Interacted with negative events to predict increases in depressive symptoms even after controlling for the proportion of variance in depressive symptoms accounted for by the unprimed inferential style stress interactions. Individuals with depressiogenic inferential styles are likely to show increases in depressive symptoms following the occurrence of negative events. At the same time, these depressiogenic inferential styles are typically latent cognitive processes that must be primed in order to be accurately assessed.

Hashmi, Khurshid and Hassan (2006) aimed at exploring the relationship between marital adjustment, stress and depression. Sample of

the study consisted of 150 working and non-working married women (working married women = 75, non-working married women = 75). Their age ranged between 18 to 50 years. Their education was at least gradation and above. They belong to middle and high socio-economic status. Urdu Translation of Dyadic Adjustment Scale (2000), Beck Depression Inventory (1996) and Stress Scale (1991) were used. Results indicated highly significant relationship between marital adjustment, depression and stress. The findings of the results also show that working married women have to face more problems in their married life as compared to non-working married women. The results further show that highly educated working and non-working married women can perform well in their married life and they are free from depression as compared to educated working and non-working married women

COPING AND ADJUSTMENT

It is the coping skills and the ability to make adjustments that determine the outcome of many stressful situations.

Study by Kamath (1997) aimed to investigate the coping patterns and social support in HIV/ AIDS individuals. Twenty wives of HIV/AIDS individuals attending the HIV/AIDS clinic at NIMHANS and Samraksha (AIDS counseling Center) at Bangalore were studied using a schedule for (a) Socio demographic Data (b) Ways of Coping Scale and (c) Perceived Social Support from family and friends. Most wives were 24-35 years old, educated up to primary school, housewives by profession, of Hindu back ground and married for 1-5 years. Most were HIV positive. The wives' preferred coping strategies were those related to "escape avoidance" and "positive appraisal" while "accepting responsibility" was least preferred. The perception of social support from the family was rated higher by the respondents among the two sources of support. Age and perceived social support from friends were both positively and significantly co related with coping abilities.

Akhani and Sharma (1999) discusses marital adjustment of Indian women in the context of their changing status affected by the different roles performed by them in the family. Marital conflict arises if the norms and the personal preferences of the husband and the wife conflict with each other or if the role performance of one spouse does not match the role expectations of the other. The paper discusses different methods of marital adjustment. Family counseling helps in promoting marital adjustment and coping with marital discord.

Aujila (2002) conducted a study to know the various mental stress management techniques utilized by women. The total sample comprised of 150 respondents divided into two categories namely working and non working, having 75 respondents in each category. Mental stress management techniques were studied under 6 headings(meditation, psychotherapy, social support, altering situations, planning and reducing responsibilities). Results show that prayer, recreation, talking, proper house arrangement and setting priorities were the most common stress management techniques utilized by women. Working women were significantly making more use of putting off certain tasks during time shortage and changing standard of job performances. Use of mental stress management techniques was found in both the categories though the frequency was more in the working women.

Gunthert, Cohen and Armeli (2002) used a 14 day diary design to evaluate the unique effects of college students' depressive and anxious symptamatology on the occurrence of specific types of daily events, primary and secondary appraisals, use of specific coping strategies, and end-of-day mood. Initial depression was associated with more negative secondary appraisals, less frequent use of social support, muted positive affective reactions to low stress ratings, and high coping efficacy ratings, and stronger reductions in positive affect in response to emotion expression coping. In contrast, initial anxiety was associated with less frequent reporting of

academic stressors and less effective use of problem focused coping. These findings suggest that depression and anxiety have unique effects on the daily stress and coping process, and they support the construct validity of Clark and Watson's (1991) tripartite model of depression and anxiety.

Horan and Blanchard (2003) examined the association between the affective traits, coping styles and neurocognitive functioning and subjective emotional responses during stressful social interactions among individuals with schizophrenia. Self reported mood was assessed in male schizophrenia out patients (n=36) and matched non psychiatric controls (n=15) during a role play test (RPT) comprised of simulated social encounters requiring assertive or affiliative skills. Results provide preliminary support for the validity of the social RPT as a paradigm for examining social stress in schizophrenia and suggest that trait Negative Affectivity and maladaptive coping are associated with individual differences in emotional responses to psychosocial stressors in schizophrenia.

Sasaki and Yamasaki (2007) investigated the causal relationships between dispositional and situational coping and health status in university freshmen. Two hundred and twenty-nine university freshmen completed questionnaires at Time 1 (immediately after university matriculation) and at Time 2 (approximately three months later) in a short-term, prospective study. Structural equation modeling was used to analyze causal relationships between four coping strategies (i.e., emotion expression, emotional support seeking, cognitive reinterpretation, and problem solving) and four health status variables (i.e., somatic symptoms, anxiety and insomnia, social dysfunction, and depression). Increases in dispositional coping predicted increases in situational coping at certain time points. In addition, increases in dispositional emotion-focused coping, such as emotion expression and emotional support seeking, predicted poor health status. This relationship was mediated by situational coping variables. Finally, increases in dispositional problem-focused coping, such as cognitive reinterpretation and

problem solving, predicted better health status. This relationship was direct or indirectly mediated by situational coping variables. Our data suggest that the use of coping skills such as cognitive reinterpretation and problem solving may promote better health and adaptation in university freshmen.

Huang et al (2008) studied the coping experiences of carers living with a schizophrenic family member. A qualitative descriptive phenomenological research methodology was employed and purposive sampling and in-depth, face- to – face interviews were used to collect data. The sample size comprised of 10 carers. The interview focused on the carers' coping experience. Narratives were analyzed according to Colaizzi's seven step method. The two most commonly used coping mechanisms that emerged from the study were psychological coping strategies (cognitive, behavioral, and emotional) and social coping strategies (religious, social, and professional support). Further more, three factors were found in the study, including, low social status, traditional help seeking behaviors and feelings of shame which may influence the coping behavior. Findings demonstrate the importance of understanding the coping experiences of carers who have a family member with schizophrenia.

A qualitative exploratory study by Kartalova- O' Doherty and Dohery (2008) investigated the experiences and needs of family carers of persons with enduring mental illness in Ireland. The currant mixed methods secondary study used extent analysis and statistical procedures to identify and explore the coping strategies emerging from the original interviews. The majority of family carers reported use of active behavioral coping strategies, some times combined with active cognitive and avoidance strategies. The percentage of carers reporting the use of active cognitive strategies were among the lowest of those whose ill relative lived in their homes, and the highest among those whose relative lived independently. Participants with identified active cognitive strategies often reported the their relative was employed or on training. Participants who reportedthe use of avoidance

coping strategies were significantly younger than participants who did not report use of such strategies. The lowest percentage of avoidance strategies was among participants whose sick relative lived independently, whereas the highest was among carers, whose relative lived in their homes. The findings highlight the importance of a contextual approach to studying coping styles and processes.

GENDER DIFFERENCES ON STRESS COPING AND RELATED ASPECTS

There are definite differences in which the two genders perceive stress and in their attempts to cope with it.

Mitchell and Hodson (1982) examined the impact of stress, personal resources, social support, institutional responsiveness, and coping upon the psychological health of battered women. Women (N=60) completed questionnaires within a week of their arrival at a shelter for battered women. Analyses of results indicated that increased levels of violence, minimal personal resources, lack of institutional and informal social support, and greater avoidant coping styles were related to lowered self-esteem and more severe depressive symptoms. The results suggest that stress, level of violence, and personal resources may have indirect effects upon functioning through their impact on coping responses and the availability of social support. The findings also suggest that women with fewer social contacts unaccompanied by their partner are less likely to receive supportive responses from friends. (PAS)

Nathawat and Rathore (1996), by employing a 2*2*2 factorial design, effects of gender, hardiness and social support on well being were examined in a sample of upper middle class elderly, retired from government jobs (100 men and 100 women). Old men disclosed higher positive affect and life satisfaction than old women. They also scored lesser on negative affect and hopelessness. Similar trend of superior well being was observed in high hardy aged and also in aged with high social support than aged with low social support. Two way interactions of ender – hardiness, hardiness – social

support, and gender – social support also influenced some of the measures of well being.

Goldman, Bressler and Vera (1997) studied to understand the sources of greatest stress for women whose families are affected by HIV/AIDS and the coping styles used by women dealing with HIV disease, and the physical and mental consequences of these coping styles. Seventy five HIV infected women with resident children participated in a semi structured interview designed to explore the psychological lives of a particularly understudied population of HIV infected individuals. The following information was collected : demographic characteristics, family attributes relationships, social support, illness symptamatology, the recent experience of physical and psychological illness and types of social support services needed to alleviate current hardships. In addition respondents completed standardized measures of stress and depression as well as the Mental Adjustment to HIV Scale (MAHIVS). Physician reports of CD4 counts were also collected as a proxy measure of HIV disease status. Participating women were primarily minorities with low income, who tended to have limited education and 2-3 children at home. All though all women were HIV positive, only about one forth of the samples had HIV positive children. Fewer than 20% of women were legally married; however, nearly three forth did have someone they considered to be a main sex partner. In more than 50% of these cases, the partners were reported to be HIV negative. The greatest source of stress for these women were financial solvency, thoughts of a prematurely shortened life, worry that their children might be removed from home, and concerns about how the illness might affect their physical appearance. Negotiating intimate relationship was also mentioned as a source of ongoing stress for these women. Among those with HIV positive children there were also worries that people would find out HIV status of their child(ren) and that school officials would not know what to do if their child(ren) had an accident or emergency at school.

Three basic styles of coping emerged from an exploratory analysis of the MAHIVS : emotion focused tasks, activity focused tasks, and anxious preoccupation. These coping styles were not related to HIV status, however, results showed that anxious preoccupation with the illness was associated with higher depression scores, greater reported symptamatology, higher levels of overall stress and the lower levels of perceived social support. While HIV positive women with children are indeed concerned with HIV related issues, those who participated in the study also emphasized that their stressors are common issues among women – general finances, their children's wellbeing, intimate relationships and physical appearances.

The study conducted by Pandey and Shipra (2000) aimed to investigate the role of job category and the type of family in coping with work stress among female personnel working in Railways, Bank, and Teaching Institutions. A3 (job category)*2(type of family: Joint and Nuclear) factorial design was used. A sample of 96 females, 16 in each cell, participated in this study. Work Stress Profile (Cooper) was administered to assess work stress related to interpersonal, physical condition and job interests. Respondents' coping styles were measured by using COPE Scale (Carver, Schiver, Weintraub). Results showed that job category and type of family had influence on work stress and coping styles. Findings indicate that groups varied on active coping style. Teachers expressed significantly better on active coping than the bank and railway employees. This trend was more clear among teachers belonging to nuclear families. Group did not differ significantly in adaptive and maladaptive coping style.

Yee and Schulz (2000) conducted the review and synthesize of the empirical research on caregiver gender and psychiatric morbidity, with the aim of answering three questions: (a) Is there greater psychiatric morbidity among female than male caregivers, (b) is the excess psychiatric morbidity among female caregivers attributable to caregiving, and (c) what factors in the caregiving situation contribute to the excess psychiatric morbidity among

female caregivers? In almost all studies reviewed, women caregivers reported more psychiatric symptoms than men caregivers. Comparisons with non caregiving community samples suggest that female caregivers experience excess psychiatric morbidity attributable to caregiving. Using a stress process model as an organizing framework, the study demonstrated that at all stages of the stress process; women are at greater risk for psychiatric morbidity than men. Directions for future research and implications for interventions and public policy are discussed.

Senthilathiban and Kaliappan (2001) outlines various psychological services that should be provided fir battered wives. It has been reported that battered wives experience sharply elevated levels of psychological distress, head aches , nervousness, depression and feelings of worthlessness, anger, humiliation and sense of injustice along with physical pain which leads to suicidal attempts. In spite of being victims of abuse, a substantial number of women remain in abusive relationships mainly as a result of culturally inherited values, lack of education and occupation. The psychological services suggested by Andrews (1990) include crisis intervention, recovery intervention, risk reduction program, social support, coping skill development and alternative options to violence for husbands.

Sharma and Mahajan(2001) conducted a study on gender differences in stress as a result of different personality variables. A study was conducted on clerical cadre staff of nationalized banks in the municipal limits of Shimla town of Himachal Pradesh. It was observed that both extrovert and introvert females experienced more stress than their male counter parts on most of the stress parameters. Neurotic females and stable males showed more stress than their corresponding counter parts.

Banu (2002) conducted a study to trace the traumatic experiences of women belonging to different economic strata in their day to day family living. The sample comprised of 30 women belonging to upper (10), middle (10), and lower (10) socioeconomic status. The upper class women were

subjected to traumatic experiences in the hands of their husbands and relatives in terms of curtailing their freedom to step out of the prescribed roles to realize her worth and self-identity. The middle class women reported mental torture from their spouses, which are reflected in their attitudes and behavior (suspicion, domination, indifference, rejection and controlling wives' movements. The lower class women were the worst victims of domestic violence. The results were attributed to socialization process, cultural value system, traditional sex role orientation, social background of the family and patriarchal values.

Calam, Bolton and Roberts (2002) conducted study on maternal depression, expressed emotion and attribution and entry into therapy for children with behavior problems. The objective was to test for associations with entry to therapy for children with behavioral problems. Maternal expressed emotions (EE), attribution, depression and parenting stress of mothers were tested. 57 mothers were assessed prior to first appointment using Camberwell Family Interview coded for EE and attributions (LACS) and completed the Beck Depression Inventory (BDI) and Parenting Stress Index (PSI). Mothers who did not attend scored higher on EE dimensions of critical comments, hostility or emotional over involvement.

Kaila(2002) conducted a study on facets of women in Mumbai. This study is a summary of studies conducted by the author during 1990 –2001, covering 4000 women in Mumbai, covering everything from perceptions on life, family occupation, gender, health issues and what they thought of their husbands. These research studies included stress, women and work, women on substance, women in power, the ring of psychosomatic problems, personal is physical, counseling at work, stress anniversary, years of marriage- years of problems, long distance marriages, she is a growing girl, the other half- wives on husbands, when she smokes, computer and women, a healthy worker. Study on 'years of marriage-years of problems' showed that married women on an average whose marriage duration was less than

ten years had perceived characteristic problems with their husbands than others had with more than ten years. The study provides an in sight that the first ten years of marriage are crucial in the development of the understanding between the two, and the later years provides a platform for better relationship.

Kumar, Singh, Mohanty, Kumar and Kumar (2002) conducted a study on the perceived burden of care as a function of diagnosis and gender. The study attempted to explore the impact of diagnosis and gender on perceived burden of care in the spouses of schizophrenic, manic, and depressive patients. A consecutive series of 210 spouses of both the genders were drawn from the outpatient department from the Institute of Mental Health and Hospital, Agra. Burden Assessment Schedule (Thara et. al, 1998) was administered. Results were analyzed through Two Way ANOVA (Diagnosis* Gender). The main effect of diagnosis was not significant on aggregate BAS scores. However, the effect of diagnosis was significant on the areas of patients' behavior and other relations. Significant gender differences emerged among the spouses of schizophrenic and depressive patients. Females perceives significantly greater burden particularly in respect of external support, spouse related physical and mental health area

Parikh and Lavakare (2002) conducted a study on the psych of Indian middle-aged women. The paper is the study of the entire repertoire of human behavior of Indian middle aged women through personality profiles and life satisfaction level. Its objective was to provide a realistic picture of their approach to life. The sample consisted of 326 educated women between 35-65 years from Mumbai. The tests used were 16 PF Questionnaire and Self Evaluation Test on Life Satisfaction covering personal, familial and social adjustment. The statistical methods employed were t Test, one way ANOVA and Correlation. Some of the common traits revealed by these women were a sober practical approach to life along with a positively inclined satisfaction

level. The negative side covered traits like apprehension, depressive trends and a tendency to underestimate themselves.

Tamres, Janicki, and Helgeson (2002) used meta-analysis to examine recent studies of sex differences in coping. Women were more likely than men to engage in most coping strategies. The strongest effects showed that women were more likely to use strategies that involved verbal expressions to others or the self—to seek emotional support, ruminate about problems, and use positive self-talk. These sex differences were consistent across studies, supporting a dispositional level hypothesis. Other sex differences were dependent on the nature of the stressor, supporting role constraint theory. We also examined whether stressor appraisal (i.e., women's tendencies to appraise stressors as more severe) accounted for sex differences in coping. We found some support for this idea. To circumvent this issue, we provide some data on relative coping. These data demonstrate that sex differences in relative coping are more in line with our intuitions about the differences in the ways men and women cope with distress.

Thomas and Vindhya (2002) explores the relationship between depression and stressful life events and the mediating impact of self esteem in female university employees age 20 –55) in India. Relatives of 300 university employees were interviewed and administered Beck Depression Inventory, Coopersmith Self esteem Inventory and the presumptive Stressful Life Events Scale. A positive relationship was observed between depression and undesirable life events. Self esteem had a more significant impact on depression in working class subjects than those in the middle class occupation. Overall, single status, longer marriage, and age were significantly associated with depression.

Siddiqui and Pandey (2003) used participants fro the last strata of the Muslim community living in the slum area, to examine the perception of economic stress and use of coping strategies. The data were collected on 280 respondents belonging to the slums located in Delhi and Allahabad.

From both the cities, 70 males and 70 females were interviewed. Results show that females in comparison to the males perceived greater poverty and also reported greater helplessness, acceptance and fatalism. However male respondents in comparison to the female reported significantly more social support.

Hoffman, Levy-Shiff and Ushpiz (2004) evaluated gender differences in the relation between stressful life events and adjustment among elementary school children. In Study I, anxiety, aggression, submissive withdrawal, and life event questionnaires were completed by 63 Israeli children. The frequency of life events was associated with increased anxiety and trends toward heightened withdrawal and aggression among boys, but not girls. In Study II, 80 Israeli mothers of elementary school children completed parallel questionnaires regarding their child. As in Study I, life events were associated among boys, but not girls, with increased anxiety and a trend toward heightened withdrawal. No gender difference arose in the association for aggression. Discussion focused on the possible roots of these findings in differential patterns of stress sensitivity, resilience, and coping, and on their ramifications for the study of cross-situational gender differences

Rao, Apte and Subbakrishna (2003) examined the role of work related factors, availability of support and coping styles as predictors of wellbeing. Sixty married working women were individually interviewed with regard to reasons for employment and support availability, and were administered the Coping Checklist and Subjective Wellbeing Inventory. On stepwise multiple regression analysis, greater use of social support seeking and less use of denials as coping styles, absence of multiple role strain, working to be financially independent, availability of support and refusal of job promotion were significant predictors of wellbeing.

Mohr, Armeli, Ohannessian, Tennen, Carney, Affleck,and Delboca (2003) used a daily process methodology to examine how the within-person

associations between negative interpersonal exchanges and mood varied as a function of sex. One hundred community residents (45men and 55 women) recorded their negative interpersonal exchanges and mood everyday for 30 days. Participants' mood was probed three times each day via palm-top computer, interpersonal exchanges were recorded daily in a structured diary. Men and women were reactive to negative interpersonal interactions, but at different times of the day. Evidence suggested that women are more likely than men to continue experiencing a negative mood from one point to the next, consistent with the hypothesis that women are more prone to ruminate on negative events.

Hagedoorn, Sanderman, Buunk and Wobbes (2004) examined a possible explanation for the frequently reported finding that female caregivers perceive more psychological distress than do male caregivers. Authors' identity-relevant stress hypothesis asserts that feelings of incompetence with respect to caregiving are more strongly associated with psychological distress in women than in men. Women who feel competent with respect to caregiving may report levels of distress as low as that of male caregivers. This study has a cross sectional design. Psychological distress (CES-D) was measured in 32 female and 36 male partners of patients suffering from various types of cancer. Furthermore, partners' perception of caregiving performance and patients' perceptions of partners' supportive and unsupportive behavior were assessed. Only among female partners were self efficacy and personal accomplishment regarding caregiving found to be positively linked to distress. Also in contrast to male partners female partners reported more distress when they acted less supportively.

Wang et al (2007) used perfusion based functional magnetic resonance imaging (fMRI) to measure cerebral blood flow (CBF) responses to mild to moderate stress in 32 healthy people (16 males and 16 females). Psychological stress was elicited using mental arithmetic tasks under varying pressure. Stress in men was associated with CBF increase in the right

prefrontal cortex (RPFC) and CBF reduction in the left orbitofrontal cortex (LOrF), a robust response that persisted beyond the stress task period. In contrast, stress in women primarily activated the limbic system, including the ventral striatum, putamen, insula and cingulate cortex. The asymmetric prefrontal activity in males was associated with a physiological index of stress responses—salivary cortisol, whereas the female limbic activation showed a lower degree of correlations with cortisol. Conjunction analyses indicated only a small degree of overlap between the stress networks in men and women at the threshold level of $P < 0.01$. Increased overlap of stress networks between the two genders was revealed when the threshold for conjunction analyses was relaxed to $P < 0.05$. Further, machine classification was used to differentiate the central stress responses between the two genders with over 94% accuracy. Our study may represent an initial step in uncovering the neurobiological basis underlying the contrasting health consequences of psychosocial stress in men and women.

MENTAL HEALTH AND RELATED ISSUES

A positive mental health speaks volumes on the perception of a person's stress, the coping styles a person might employ to tackle stress, and his/her subsequent sense of wellbeing.

McGlashan and Carpenter Jr. (1981) did a replication of a study where it was found that a positive integrating attitude toward illness correlated with good outcome in a follow up of recovered schizophrenic patients. In similar research at NIH, the authors obtained partial replication of these findings. Specifically the less negative patients were about their illness and future, the better the outcome. A very positive attitude was not associated with good outcomes. Hence the absence of a negative attitude appears critical. The authors failed to find a relationship between integration or isolation of the psychotic experience and outcome, which suggests the incidence of an unconscious psychological coping style from a conscious attitude and opinion about the illness and the future.

Sonuga-Barke and Mistry (2000) conducted the study on the effect of extended family living on the mental health of 3 generations within two Asian communities. The present study is a replication of a study by Shah and Sonuga-Barke (1995) and extends this study by exploring the impact of nuclear and extended family living on the mental health of 3 generations (children, mothers, and grandmothers) in British Hindu as well as Muslim communities. 44 Muslim and 42 Hindu families participated in the study. The mental health of mothers and grandmothers and the behavioral problems of the children (aged 5-11) were examined. Both mothers and grandmothers completed the Hospital Anxiety and Depression Scale. Children's behavioral adjustment was rated by their teachers using Rutter Scale. Children and grandmothers were better adjusted in extended families. In contrast mothers were better adjusted in nuclear families. This interaction between family type and generation was evident in both Muslim and Hindu families and did not appear to be mediated by other variables as acculturation. Furthermore, mothers' and children's' adjustment was significantly correlated with grandmothers', but not with mothers' mental health in extended families.

Despite a strong body of evidence for an important association between marital discord and depression, issues of causality have been difficult to disentangle. In an attempt to better understand aspects of the marital discord/depression, Christian-Herman, O'Leary, and Avery-Leaf (2001) assessed the impact of severe negative marital events on the development of depression in women with no prior history of major depression (N=50). The specific goals of the study were to examine rates of depression occurring after severe negative marital event and to determine the types of events in marriage that wives perceived as severely negative. The rate of Major Depressive Episodes in this group of women experiencing a severe negative marital event (38%) was significantly higher than reported incidence rate. Additionally participants had significantly elevated rates of depressive symptamatology both shortly after the event and 2 months later. The most frequently reported negative events were separation/divorce,

extramarital affairs, and physical aggression. Path analysis indicated that marital discord predicted later depressive symptoms but that depressive symptoms did not predict later marital discord. The strong association between severe negative marital events and subsequent depression demonstrated that negative marital events predict depression even in the absence of a history of depression.

Jain and Gunthey (2001) conducted a study to determine the level of mental health in relation to dual role conflict among workingwomen. It is hypothesized that level of mental health, pattern of problem and marital adjustment among working women will significantly differ from non working women. 120 working and 120 non-workingwomen were administered Mental Health Checklist by Kumar, Marital Adjustment Questionnaire by Kumar and Rastogi, and Problem Checklist by Joshi. This is an ex-post-facto study in which marital adjustment and problem pattern were taken as IV and mental health was taken as DV. Results indicated that both the groups differed significantly on their mental health score.

Haslam and Ernst (2002) examined whether lay people think about mental disorder in terms of underlying essences and whether such 'essentialist' beliefs guide their inferences about mental disorders. Participants read summaries of new scientific evidence purporting to show that particular disorders were more homogenous, biologically base, immutable, inductively potent, or sharply bounded than had previously been thought, and rated the extent to which this evidence altered their beliefs about the nature of the disorders when specific essence-related beliefs were manipulated in this manner. In addition, participants thinking about mental disorders was guided by a cluster of 'natural kind' beliefs, which represent disorders as biologically-grounded, discrete, fixed and historically invariant entities.

Vaillant (2003) points out pitfalls in research on mental health – equating average with healthy, failing to distinguish trait from state,

overlooking cultural norms, and conversely blindly accepting the culture's values. He describes six models and provides history and research needs for each. The first model being 'above normal' is epitomized by DSM-IV's axis V, the Global Assessment of Functioning Scale. High scores represent superior functioning in a wide range of activities, life's problems never seem to get out of hand is sought out by others because of his/her many positive qualities. The goal of the 2nd model positive psychology is intervention to maximize positive qualities such as self efficacy. Maturity and Erikson's a developmental tasks (identity, intimacy, generativity, integrity) are the basis of the 3rd model. The author adds 2 other tasks : career consolidation and 'keeper of the meaning'. The 4th model is emotional or social intelligence. Surprisingly, subjective wellbeing, the 5th model is as much a characteristic of temperament as of a benign environment. The last model, resilience, is epitomized by DSM-IV's Defense Function Scale which categorizes coping mechanisms in terms of adaptional value.

Schumacher, Corrigan, and Dejong (2003) examined the impact of three cues –bizarre behavior, poor social skills, and low physical attractiveness – on mental illness stigma. One hundred seventeen research participants read four vignettes about meeting a person in public who varied in symptoms (positive versus negative symptoms) and appearance (clean versus unkempt). After completing each vignette, they answered questions about three types of stigmatizing attitudes : dangerousness, threat, and social avoidance. Result suggests research participants rated the person in the vignette as more dangerous, threatening, and worthy of avoidance when he manifested positive symptoms compared to negative symptoms. Physical appearance interacted with symptoms; persons in the vignette who were unkempt were more stigmatized when they manifested negative rather than positive symptoms. Stigma related to physical appearance interacted with the perceiver's gender; women were more likely to stigmatize unkempt people in the vignettes.

The study of Reinke, Corrigan, Leonhard, Lundin and Kubiak (2004) expanded on earlier research by the authors that show that contact with people with mental illness has significant effects on changing stigmatizing attitudes. Two factors that affect contact are examined in this study : the medium through which contact is experienced and the level of stereotype disconfirmation engendered in the contact. One hundred sixty four individuals were randomly assigned to one of five conditions. Three of the conditions allowed the authors to examine effects of medicine on stigma control, in vivo contact with moderate disconfirmation, and videotaped contact with moderate disconfirmation. Along with the moderate disconfirmation videotape, two additional videotaped conditions – little or no disconfirmation and high disconfirmation – defined the three groups of the second set of hypotheses on disconfirmation. Research participants completed the Social Distance Scale prior to being assigned to conditions and immediately upon completion. In terms of the medium of contact, results showed that both videotaped and in vivo contact led to significant changes in stigmatizing attitudes. Two interesting results were found in terms of level of disconfirmation. First viewing a videotape of the person with mental illness that does not disconfirm the stereotype (the person is manifestly psychotic) does not change the stigmatizing attitudes. Second videotapes of people who moderately and highly disconfirm the stereotype lead to significant improvement in the attitudes, with non significant trends suggesting that moderate disconfirmation yields better effects.

The study of Crsake, Edlund, Sullivan, Roy-Byrne, Sherbourne, and Stein (2005) estimated the extent of perceived unmet need for mental health treatment among individuals with panic disorder on primary care settings, investigated the determinants of unmet needs, and assessed barriers to care. Data from baseline interviews in a clinical trial that investigated primary care treatment of panic disorders. Participants were asked whether there was anytime in the past 3 months when they did not get as much care for emotional or personal problems as they needed or whether they had delays

in getting care. Patients who endorsed unmet needs were asked about specific perceived barriers. Logistic regression was used to investigate the determinants of unmet needs. Of the 231 patients eligible for the study, 88 (33%) endorsed unmet need for emotional or mental health problems. Individuals with worse mental health, those who were more worried about panic, and those without sick pay were significantly more likely to report unmet need. Commonly reported barriers included being unable to find out where to go for help (43%), worry about cost (40%), lack of average health plan (35%) and being unable to get an appointment soon enough (35%). The relatively low level of patient reported unmet need for mental health treatment among primary care patients with panic disorder suggests that efforts to improve treatment of panic disorder should include patient education about mental illness and the effective treatment available. Although discussion of barriers to care has traditionally centered on stigma and economic factors, the result suggest that simple logistic factors, such as not knowing whom to call for help are also important barriers.

Watson et al's (2006) study of people with a recent relapse of their psychosis examines the relationship between illness perception, their emotional responses and their attitudes to medication One hundred patients diagnosed with a non-affective psychotic disorder were assessed within 3 months of relapse. Measures included insight, self-reported illness perceptions, medication adherence, depression, self-esteem and anxiety . Illness perceptions about psychosis explained 46, 36 and 34 % of the variance in depression, anxiety and self-esteem respectively. However, self-reported medication adherence was more strongly associated with a measure of insight .Negative illness perceptions in psychosis are clearly related to depression, anxiety and self-esteem. These in turn have been linked to symptom maintenance and recurrence. Clinical interventions that foster appraisals of recovery rather than of chronicity and severity may therefore improve emotional well-being in people with psychosis.

WELLBEING

Wellbeing is often considered to be an appropriate outcome measure indicating the way in which people perceive and react to their health and other non medical aspects of their lives.

Bryant and Veroff (1982) conducted a study on the structure of psychological wellbeing and its socio historical analysis. This study used confirmatory factor analysis to explore dimensions of self evaluations with data collected from 2 nation wide representative sample, cross sectional surveys of US adults – one conducted in 1957 and other in 1976. Eighteen indexes of wellbeing were constructed from items common to both surveys, which assessed feelings of wellbeing, perception, symptoms of distress, and various aspects of adjustment in marriage, parenthood and work. Confirming an expected tripartite model, the same three dominant factors involving unhappiness, strain, and personal inadequacy, emerged for both men and women in both 1957 and 1976. The emergence of this structure supports two prevailing notions about self-evaluations. First, positive evaluation (positively anchored Unhappiness items) and negative evaluation (the negatively anchored Strain items) are related, but clearly separate dimensions; and second, perceived competence in handling one's life is a dimension related to but distinctly separate from positive and negative evaluations. Comparative analysis revealed that (a) year differences are stronger than sex differences in the structuring of psychological wellbeing, (b) historical changes in the structure of wellbeing has been greater for men than for women, and (c) structural sex differences have diminished in1976 relative to 1957. Evidently men and women are becoming more similar in the ways they define wellbeing, with this historical convergence due to mostly shifts for men. These results are discussed in terms of historical changes in sex roles, through which men have begun to base their self evaluation less on work related issues and more on family life, whereas women have shown a lesser opposite trend.

The study of Wadhwa (1988) aims to compare the quality of marital life(QML) in schizophrenic and depressed patients and to examine the association between expressed emotion (EE) and QML in these clinical groups. Thirty married depressed patients and 30 married schizophrenic patients aged 20-25 tears were assessed using a Socio Demographic Data Sheet, the Level of Expressed Emotion Scale and the Marital Quality Scale. The groups did not differ in global EE or in specific EE factors. Both groups perceived a comparably poor QML. On individual factors of the Marital Quality Scale, however, some differences between groups emerged. A significant association was seen between EE and QML. Significant predictors of QML in the depressed groups were overall level of expressed emotion and duration of illness, whereas for the schizophrenic groups only the overall level of EE predicted QML.

Nandhini and Parvathi (1996) conducted a study on institutionalized and non institutionalizes senior citizens. The aim of the study was to examine the sense of wellbeing and depression among the chosen sample. A sample of 30 non - institutionalized and 21 institutionalized senior citizens were chosen for the study. The senior citizens were matched on age, occupational status and on pension. The tools used for the study include (a) Beck's depression Scale and (b) PGI Sense of Wellbeing Scale. The results obtained from the study indicated that there were no gender differences on the levels of depression and sense of wellbeing.

Krishna (1997) conducted a study which examined the subjective wellbeing and the quality of marital life of HIV infected persons as perceived by themselves and to assess their mutual effects. An exploratory study was conducted at a private general hospital at Bangalore. Thirty male HIV infected respondents were studied using (a) a semi structured Socio Demographic Data Sheet (b) Subjective Wellbeing Inventory (c)Marital Quality Scale. The respondents were 21-40 years old predominantly from a Hindu nuclear families and arranged marriage backgrounds. Most

respondents reported a poor quality to marital life. The subjects experienced low subjective wellbeing and poor quality to marital life as compared with persons without HIV infection. Older respondents perceived higher wellbeing. Occupation, type of family, type of marriage and spouse' HIV status did not have any bearing on subjective wellbeing and marital quality. A good marital quality without any significant disturbances appeared to foster wellbeing among the HIV infected individuals.

Study by Jaimon (1998)aimed to assess the subjective wellbeing of the caregivers of dementia patients. Thirty caregivers of dementia patients were selected from the inpatient and outpatient departments of Neurology and Psychiatry, NIMHANS by using (a) Socio Demographic data (b) Subjective Wellbeing Inventory (c) Family Burden Schedule (d) Social Support Resources. Results indicated that (a) majority of the respondents reported severe burden, (b) caregivers were satisfied with the social support (c) majority of them had lower levels of subjective wellbeing, (d) socioeconomic strata showed a significant difference with burden (e) subjective wellbeing differed with duration of illness.

Marteno and Addington (2001) conducted the study to attempt to understand the experience of family members of individuals with schizophrenia. More specifically, authors wanted to determine whether a measure of care giving would be a stronger predictor of the psychological wellbeing of families who have a member with schizophrenia than a measure of burden. Forty one family members of 30 individuals with schizophrenia were recruited. A measure of burden, a measure of the experience of care giving, and the duration of illness were used to determine the best predictor of psychological wellbeing. Regression analysis indicated that the strongest predictor of psychological wellbeing was the negative scale of the Experience of Care giving Inventory (ECI). There was also a significant relationship between poor psychological wellbeing and short duration of illness. The findings of the study indicated that family members are

significantly distressed as a result of having a family member with schizophrenia. There is no support for using newer scales, like the ECI. Furthermore increased family support is required in the early stages of the illness.

Verma, Nehra, Malhotra, and Sharma (2002) conducted study on further data on PGI General Wellbeing measure. PGI General Wellbeing measure has been constructed as a simple easily administered, reliable, valid, and quick to administer tool in Hindi to assess the subjective wellbeing of normal, healthy, and clinical population of our country. Further data on this measure is provided on 75 patients (75 COPD mild and 75 COPD advanced cases). The types of family (nuclear Vs. joint), occupation, income, smoking habit, duration of disease, type of lung cancer, have no significant impact on the scores. But lung cancer patients scored lower than normals, and advanced COPD cases showed lower scores than COPD mild cases. Similarly hearing loss subjects (56 moderate, 32 severe loss) showed lower initial wellbeing scores but the introduction of hearing aid led to significant improvement in both the patient groups though it still remained about the same in the comparable control (n==60) group.

Paradise, and Kernis (2002) conducted the study to examine the extent to which self esteem (SE) Level and SE stability predicted score on Ryff's (1989) multidimensional measure of psychological wellbeing. Main effects for SE Level emerged on all six subscales, indicating that high self esteem was associated with greater wellbeing than was lower self esteem. In addition, main effects for SE stability emerged for the autonomy, environmental mastery, and purpose in life subscales, indicating that stable SE was associated with higher scores than was unstable SE. Finally, SE Level* SE Stability interactions emerged for the self acceptance, positive relations, and personal growth subscales indicating more complex relationships between self esteem and these aspects of wellbeing.

Chang and Sanna (2003) examined optimism-pessimism as a moderator of the link between accumulated negative life stress (over the past year) and psychological adjustment (depressive symptoms and life satisfaction) and physical symptoms and vulnerability to illness in a large sample of college students (N=560). Results indicated that optimism-pessimism and negative life stress significantly predicted each outcome. Moreover for all the outcomes, except for life satisfaction, a significant Optimism-Pessimism*Accumulated Negative Life Stress was found. As expected, a plot of the significant interactions indicated that optimism, but not pessimism, exacerbated the associations between accumulated negative life stress and poor psychological and physical outcomes.

Huppert and Whittington (2004) compared the characteristics and determinants of positive and negative mental states in a population sample. A novel analysis of data was undertaken from the General Health Questionnaire (GHQ – 30) which was completed by 6317 participants in the Health and Lifestyle Survey at Time 1 and 3778 at Time 2, seven years later. Authors derived a positive wellbeing scale (POS – GHQ) based on positive responses to the positive items of the GHQ – 30 and compared it to a standard symptom measure (CGHQ). Discriminant function analyses were performed to establish with demographic, health and social variables best accounted for scores on each scale. The distributional properties of the two scales, together with the results of the discriminant analyses demonstrate a degree of independence between positive and negative wellbeing. Over one-third of the sample obtained either low scores on both positive and negative wellbeing measures or high scores on both measures. Disability and lack of social roles were important determinants of psychological symptoms, but had less influence on positive wellbeing. Having paid employment was an important determinant of positive wellbeing but had less influence on psychological symptoms. It was also found that 7 year mortality was predicted more strongly by the absence of positive wellbeing than by the presence of psychological symptoms.

Pinquart and Sorenson (2004) conducted the meta-analytic study to give a systematic review of research on depression and the subjective wellbeing of caregivers. Authors integrated results from 60 studies on informal caregivers' subjective wellbeing (positive affect, life satisfaction) and contrasted them with the results of studies on caregiver depression. Analyses were based on a two-factor model of subjective wellbeing that distinguishes between positive and negative dimensions of wellbeing (happiness and depression). The strongest effects were domain specific: uplifts of caregiving were associated with subjective wellbeing and caregiving stressors were associated with depression. In addition, lower levels of caregivers' subjective wellbeing were weakly related to care receivers' physical and cognitive impairments, as well as behavior problems, but not to the amount of caregiving. Type of care recepients' illness and the measure of wellbeing moderated the association between stressors/uplift and subjective wellbeing.

Suhail and Chaudhry (2004) determined the prevalence and predictors of personal wellbeing in an Eastern Muslim culture, Pakistan. The study also aimed to compare the current ratings of subjective wellbeing with those obtained from other areas of the world. To make this survey representative of the vast majority of Pakistani people, a total of 1000 people with an age range of 16-80 living in diverse areas of Lahore were contacted. Ten localities ranging from upper class areas to congested inner city locations and to Kacchi Abadies (temporary houses built in caravan) were visited. Apart from demographic information, responses of the survey subjects were collected on multiple dimensions : personality traits, self esteem, work satisfaction, marital satisfaction, religiosity, and social support. General wellbeing was assessed using Faces Scale and Ladder Scale of Life Satisfaction. The current findings, consistent with previous world wide reports showed that the number of happy people exceeds those who are unhappy, and also that Eastern people are as happy and satisfied as people from many Western countries. Work satisfaction, social support, religious

affiliation, social class, income level, and marital status and satisfaction were found to be better predictors of subjective wellbeing.

Woolfson (2004) conducted the theoretical study aimed to address family wellbeing of families where there is a disabled child. This was done by integrating perspectives from a social model of disability with psychological research on the role of cognitive change in families' coping and adjustment to having a disabled child. Negative societal attitudes to disability identified by a social model of disability are interpreted with respect to how they might translate to parent view of their disabled child within the family. Resultant parenting beliefs and their possible implications for family interactions, child behavior and family health and wellbeing are explored within this framework.

Masthoff (2006) aimed to get more insight into the relationship between Quality of Life (QOL) and psychiatric disorder. It was hypothesized that QOL would be negatively related to the presence as well as the severity of psychopathology. A random sample of Dutch adult psychiatric out patients (n=410) completed the WHO Quality of Life Assessment Instrument (WHOQOL). In addition DSM IV axis I and II diagnoses were obtained. Comparisons were made between scores of the psychiatric out patient, diagnostic subgroups within this population and the scores of general population. Compared with the general population, psychiatric outpatients scored significantly worse scores on all aspects of QOL. Within the group of outpatients, participants with DSM IV diagnosis had worse scores than those without. Participants with co morbidity had the worst QOL. It is concluded that QOL scores are negatively related to both the presence and the severity of the psychopathology, and that the presence of a personality disorder plays a role in subjectively experienced QOL.

BURDEN OF CARE

Caregiving in itself is a sressor. Caregiving, especially when it is prolonged causes depressive symptoms in the care taker. This happens in addition to the other day-to-day stressors and hassles that may crop up from

time to time. Apart from these direct stressors, the caregiver often has to cope with indirect stressors like losing close ties and social support.

The aim of the study by Gilhooly (1984) was to present findings concerning a variety of factors expected to influence directly or indirectly as mediators of the psychological wellbeing of persons caring for a dementing relative in the community. The sample included both co resident and non resident supporters, and the data were collected via a semi structured interview. Sex of dependent, sex of supporter, satisfaction with help from the relatives, blood/role relationship, duration of care, frequent visits from a home help and community nurse were significantly correlated with supporters' morale and mental health. The directions of these correlations were however not always as expected; for example, the longer the duration of caregiving, the higher the supporters' morale and better the supporters' mental health. It was interesting to find that the level of impairment and help from family and friends were not significantly associated with morale and mental health of supporter.

Francell, Conn and Gray (1988) examined the families' burden of care for chronically mentally ill relatives. Eighty six caregivers participated in small group interviews about their experience of burden in caring for mentally ill relatives. Families experienced profound burdens as a result of their interactions with the mental care system, particularly in negotiating crisis situation; acting as patient advocates and case mangers; obtaining adequate community resources, continuity of care, and information; dealing with legal barriers; and communicating with mental health professionals. Recommended methods of reducing family burden and improving the care of the mentally ill who reside in the community are family education, inclusion of the family, treatment decisions, changes in current mental health laws, redirection of professional training, and development of mobile crisis teams.

Robinson (1990) studied the relationship of caregiver health, past marital adjustment, and received social support to caregiving burden in 78

wives (aged 47-85 years) who served as primary caregivers to husbands with irreversible memory impairment for an average of 4 years and 10 months. In addition, socioeconomic status (SES) and attitudes towards asking for help were investigated. Past marital adjustment (as measured by the Marital Adjustment Test) was a significant predictor of subjective burden and accounted for 20% of the total explained variance. SES and attitude toward asking for help were significant predictors of objective and accounted for 12% of total variance. Received social support did not predict caregiver adjustment.

Chandra (1994) conducted a study on burden and coping patterns in families of patients with OCD. The objectives was to (a) study the socio demographic profile of patients with a diagnosis of OCD (b) study the nature and degree of burden faced by families of these patients (c) study the nature of coping patterns in the families of these patients. Study was conducted in the out patient department of NIMHANS. Population considered was the registered and diagnosed cases of OCD from November 1992 to May 1993. Study was an exploratory one and sampling was purposive. The tools used for data collection were (a) Interview Schedule to collect socio demographic details of patients and their families (b) Sheila Pai's Interview Schedule for assessing burden on the family of a psychiatric patient (c) Coping Checklist developed by Rao (1986). Data was collected from key caretakers of patients. They were interviewed to elicit burden and coping patterns using the Interview Schedule and the 2 scale. Data analysis was carried out using descriptive statistics like frequencies and percentages; where necessary chi square and correlation tests as well as analysis of variance. Analysis of burden revealed that a greater degree of burden was faced by families of patients from an older age group with a long - standing duration of illness. Coping patterns in families of older patients, occasionally males with duration of illness between 6 months to 9 years was found to be maladaptive. With increase in scores of different areas of burden the overall burden increased and increased usage of predominantly healthy coping

mechanisms resulted in an increase in overall coping score. Increase in the scores of different domains of burden was associated with an increase in score of predominantly healthy coping mechanisms. It was however noticed that with increasing psychological burden faced by families, they tend to fall back on a mixed repertoire of coping.

Eakes (1995) investigated the incidence of chronic sorrow in parents of chronically mentally ill children. A convenience sample of 10 parents (4 couples and 2 mothers) of adult children diagnosed with either schizophrenia or bipolar disorders were interviewed using the Burke/NCRCS Chronic Sorrow Questionnaire (Caregiver Version). Findings showed that 8 out of 10 parents experienced chronic sorrow. These grief related feelings were most often triggered by the unending caregiving responsibilities parents described. Those who evidenced chronic sorrow indicated that healthcare professionals could assist them by providing information about their child's illness and by involving them in the treatment process.

Barrowclough, Tarrier, and Johnston (1996) investigated the level of distress in relatives at the time of acute episode of illness in the schizophrenia sufferer. Guided by the attributional literature on the prediction of distress and depression, the association between relatives' distress and their explanations and beliefs concerning the illness is examined in the context of the expressed emotion status the relative. The study found that although distress levels were unrelated to the relatives' beliefs about the patients' role in negative events, beliefs that illness events were caused by factors internal to the relatives themselves ('self blaming' beliefs) were associated with distress in the relatives. The authors argue that understanding the cognitive appraisal processes involved in how caregivers perceive schizophrenia is important to understanding their response to the illness and helping them to adapt to the problem.

Horwitz, Reinhard, and Howell-White (1996) views caregiving as a process of mutual exchange. They tested the hypothesis that how much

support a mentally ill family member receives depends on how much support they provide to other family members. The authors also examined whether or not reciprocity depends on the role relationship between recipients and providers of care, the level of patient symptamatology, co residence and several socio demographic characteristics. The sample includes 66 patients who have at least one sampled parent or sibling. The results indicated that the amount of support patients give to parents and siblings is very strongly associated with how much support they receive from family members. In comparison to the other variables considered here, patient support provision is by for the best predictor of the amount of family support. These results indicate that it is worthwhile to examine caregiving in families with a member who is seriously mentally ill as a process of mutual exchange.

Mueser, Webb,Pfeiffer, Gladis, and Levinson (1996) compared the burden that specific problem behaviors of patients with schizophrenia or bipolar disorder placed on relatives and evaluated the accuracy of mental health professionals' judgement of the burden. A questionnaire was developed to assess the burden of 20 common problem behaviors associated with manic, positive and negative symptoms. The questionnaire was given to 48 relatives of patients with schizophrenia or bipolar disorder. In addition, 39 mental health professionals completed separate questionnaires indicating the amount of burden they believed relatives experienced due to these behaviors. Relatives of patients with bipolar disorder rated manic symptoms as more burdensome than did relatives of patients with schizophrenia , but relatives in the 2 groups did not differ in their ratings of burden associated with positive or negative symptoms. Professionals' perceptions of the burden associated with manic symptoms were relatively accurate, but they tended to underestimate the burden of positive and negative symptoms experienced by relatives of patients with bipolar disorders. Psychiatric diagnosis may be of limited value in understanding the burden relatives experience due to specific psychiatric symptoms. Professionals are encouraged to assess the burden that is

associated with specific problem behaviors regardless of psychiatric diagnosis.

Neog and Bhagabati(1998) conducted the study to measure the frequency and severity of burden on the families of schizophrenic patients, to study the relationship of burden on the family with Socio demographic factors, to measure social dysfunctioning of the schizophrenic patients and to evaluate the correlation between social dysfunctioning and burden on the family of schizophrenic patients. 100 consecutive schizophrenic patients were taken from the psychiatric OPD of Guwahati Medical College for the study. Out of the 100 families 78 reported burden on the household. Analysis of data showed that duration of illness has a statistically significant positive correlation with burden on the family. Analysis of correlation between burden and social dysfunction indicates that a positive correlation exists between burden on the family and social dysfunctioning due to causal effects of the patients.

Phelan, Bromet, and Link (1998) examined perceptions of and reactions to stigma among 156 parents and spouses of a population based sample of first admission psychiatric patients. While most family members did not perceive themselves as being avoided by others because of their relatives' hospitalization, half reported concealing the hospitalization at least to some degree. Both the characteristics of the mental illness (the stigmatizing mark) and the social characteristics of the family were significantly related to levels of family stigma. Family members were more likely to conceal the mental illness if they did not live with their ill relative, if relative was female, and if the relative had less severe positive symptoms. Family members with more education and whose relative had experienced an episode of illness within the past 6 months reported greater avoidance by others.

Perlick, Clarkin, Sirey, Rane, Greenfield, and Rosenheck (1999) evaluated the impact of illness beliefs on the burden reported by family

caregivers of people with bipolar illness. The multivariate relationships between symptomatology and family illness beliefs and report of burden were examined at baseline among caregivers of 266 patients with Research Diagnostic Criteria diagnosed bipolar illness who were subsequently followed for 15 months. At baseline, 93% of caregivers reported moderate or greater distress in at least one burden domain. As a group, caregiver illness beliefs (illness awareness, perception of patient and family control) explained an additional 18.28% of variance in burden experienced beyond the effects of the patients' clinical state and history. Caregivers of patients with bipolar illness report widespread burden that is influenced by beliefs about the illness.

Karp, and Tanarugsachock (2000) based on 50 in depth interviews, considers how caregivers to a spouse, parent, child or sibling suffering from depression, manic-depression or schizophrenia manage their emotions over time. By considering the turning points in the joint career of caregivers and ill family members, the analysis moved beyond studies that link emotions to particular incidences, momentary encounters, or discrete events. Four interpretive junctures in the caregiver-patient relationship are identified. Before diagnosis, respondents experience emotional anomie. Diagnosis provides a medical frame that provokes feelings of hope, compassion and sympathy. Realization that mental illness may be a permanent condition ushers in the more negative emotions of anger and resentment. Caregivers' eventual recognition that they cannot control their family members' illness allows them to decrease involvement without guilt. The article concluded with a call for research that understands that emotion in groups, settings or organizations is linked to their distinctive histories.

Marimuthu, Prashanth, John, and Russel (2000) aims to explore the prevalence of psychiatric morbidity among the primary caregivers (PCG) and the significant social, demographic and illness variables associated with morbidity. 103 consecutive primary caregivers who satisfied the selection

criteria formed the study sample. Semi structured interview and General Health Questionnaire – 30 were administered to screen the psychological morbidity of PCG. The ICD –10 diagnoses was further corroborated with Brief Psychiatric Rating Scale. Bivariate correlation with Pearson's correlation test and multiple regressions were used to measure the association between the social, demographic, illness variables and psychiatric morbidity of PCG prevalence of psychiatric morbidity among the PCG was 30%. Majority of PCG were females (52.4%) and from an urban background (53.4%), 40% belonged to low SES and 32% had a secondary school education. Schizophrenia was the common diagnosis among the patients. SES (p=0.003), stigma (p=0.01) and education of the PCG (p=0.03) were significantly correlated to the morbidity among the PCG.

Barrowclough, and Lobban et. al (2001) examined the use of a modified form of The Illness Perception Questionnaire (IPQ) to investigate illness models in a sample of carers of schizophrenic patients. 47 carers participated. The psychometric properties of the modified IPQ were examined, and a number of carer and patient outcomes were investigated in relation to carer scores on the illness identity, consequences, control cure and timeline subscales of the modified IPQ. These outcomes included measures of carer distress and burden, expressed emotion dimensions and patient functioning The modified IPQ were found to be a reliable measure of carers' perception of schizophrenia. Carer functioning, the patient – carer relationship, and patient illness characteristics were associated with different dimensions of illness perceptions. The findings support the proposal that carer cognitive representations of the illness may have important implications for both carer and patient outcomes in schizophrenia.

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Bland and Darlington (2002) explored the importance and meaning of hope for family members of people with mental illness. Focused in-depth interviews with 16 family members in Queensland and Tasmania, Australia were used. The data confirmed the argument that hopelessness appears to be central to a family's coping with the impact of mental illness. Their definitions of hope, descriptions of what they hoped for, and the sources of their hope reflect issues of future orientation, positive expectation and realism. Families drew their hopefulness from both formal and informal support, from within and without.

Jayakumar, Jagadheesan and Verma (2002) conducted a comparative study of carers' burden in obsessive compulsive disorder and schizophrenia. For this study key relatives of patients with either OCD (n=30) or schizophrenia (n=41) were evaluated with 40 item Burden Assessment Schedule (BAS). In comparison with schizophrenia group, caregivers in OCD group had significantly high mean scores for the domains of the spouse related and caregivers' strategy factors of BAS. The degree of burden, evidenced by mean scores was comparable between groups for other domains of BAS. Spouses and unemployed caregivers in OCD group had significantly elevated mean total burden scores. The findings suggest that

caregivers' burden imposed by OCD is either excess or nearly comparable to that of schizophrenia.

Jungbauer and Angermeyer (2002) based on the analysis of 42 in-depth interviews, highlighted different aspects of the subjective burden experienced by parents and spouses of patients suffering from schizophrenia. The onset of a schizophrenic disorder and acute episode during the later course of the disease led to considerable emotional distress for the patients' caregivers. In everyday life with the patient, parents and spouses experienced a comparatively less dramatic chronic burden whish nevertheless can severely affect their living situation and wellbeing. Caregivers often feel disappointed and dissatisfied with the information and co-operation offered by psychiatric institutions. Parents and spouses perceived the caregiver burden differently, although there are some apparent similarities. The study reveals that the symptoms of a schizophrenic disorder as well as different family roles contribute to the subjective burden of parents and spouses. Supportive assistance for schizophrenic patients' caregivers should address their particular needs more adequately.

Stanley and Standen (2002) conducted the study whose purpose was to apply Weiner's (1986) Attributional Model of Helping to the carers of clients presenting with challenging behavior. A number of predictions were tested (a) that aggressive, destructive and self injurious behaviors would differentially affect carers' ratings of attributional dimensions (b) that carers' propensity to help would be mediated by positive affect rather than optimism (c) that optimism would be reduced by a perceived stable cause such as clients' level of dependency. The participants were 50 care staff working in challenging behavior day services, who were presented with 6 case studies to rate. A2 factor repeated measure design was employed to examine the effects of challenging behavior and dependency on carer's ratings of attributional dimensions, affect, optimism, and helping correlational analysis

was employed to examine the relative effects of positive affect, negative affect and optimism on carer's propensity to help. All three predictions were confirmed. The more independent and outer directed the challenging behavior, the greater the carer's attributions of control and negative affect and the less propensity to help. The more self directed and dependent the patients' challenging behaviour, the greater the carer's attribution of stability, positive affect and propensity to help.

Veltman, Cameron, and Stewart (2002) documented caregivers' perspectives on both the negative and positive aspects of caregiving. A qualitative approach was used. Data collection involved 20 in-depth, audio taped, semi structured interviews focusing on caregivers' positive and negative personal experiences with caregiving to a relative with mental illness. Caregivers reported common negative impacts but also beneficial effects such as feelings of gratification, love and pride. Main themes included stigma, systems issues, life lessons learned, and love and caring for the ill relative. This study counter blames the predominantly negative consequences previously reported and adds to the emerging literature on positive aspects of caregiving. Mental health professionals need to help caregiving families make choice and to improve their challenging situations and identify the rewards of caregiving and to advocate for increased systemic supports to ease caregiver burden.

Bhatia, Tucker and Kapoor (2003) attempted to study the caregivers' experience of burden in relation to the patients' disability (functional and psychotic) due to chronic mental illness such as schizophrenia. The sample included patients with schizophrenia from in-patient and out-patient departments at the Department of Psychiatry, All India Institute of Medical Sciences, New Delhi, and their key informants. A total of 32 patients and their caregivers were included in the study (23 patients were males and 9 were females). Mean age of male patients was 20 years and for female patients was 36 years. Ninteteen caregivers were males and 13 were female

carers. Mean age of male caregivers was 41 years and that of female carers was46 years. Out of 32 caregivers 18 were employed and 14 were not employed. Family Burden Interview Schedule (Pai and Kapur, 1981) was used to assess both subjective and objective burden perceived by the caregiver. Schizophrenia Research Foundation Social Functioniing Index (Padmavati et al,1995) was used to assess the extent of disability in the patient. Brief Psychiatric Rating Scale (Overall and Gorham,1962) was used to measre the severity of psychiatric disorders and a semi structured questionnaire was used for information regarding the patients and caregivers' Socio demographic details. Findings showed that with increase in severity of patients' illness, both in terms of symptomatology and length of illness, caregivers perceived greater burden. Outcomes included disruption of daily routine, work and leisure and interactions outside the home. Caregivers were also seen to report more burdens in cases where they perceived inadequate support from other family members either in the form of helping hands for caregiving tasks or pooling resources. The amount of burden perceived was also seen to vary with the family relationship to the patient, highlighting the fact that not only severity of the illness, but also familial characteristics of relationship to patient and the size of the family are significant indicators of burden experienced by caregivers. The central point of the findings of this research is that the caregivers' concerns and problems in caring for patients with schizophrenia are a product of the interaction between the severity of the disease and the personal developmental and social contexts in which it unfolds. Consequently, counseling and psychoeducational programs for the carers must be developed by health care professionals, so as to enable carers cope effectively not only with burden they are experiencing, but in doing so are able to provide the most effective care to their ill member of the family.

Elliot and Shewchuk (2004) examined the relation of social problem solving abilities to distress experienced by family members assuming a caregiving role for a loved one who had recently incurred a severe physical

disability. Family members completed measures of problem solving, depression and health, while their loved one participated in an inpatient rehabilitation programme. Correlational analysis indicated that a negative problem orientation was significantly predictive of caregiver distress, regardless of the degree of physical impairment of the care recipient. Women reported more distress on several measures than men, and disability severity was also associated with depression and impaired social functioning. Family members with greater negative orientation, maybe at a risk to develop psychological and health problems, upon assuming a caregiver role.

Reinares (2004) assessed the effects of psycho educational family intervention on bipolar patients' caregivers, including assessment of the caregivers' burden. Forty five medicated euthymic bipolar outpatients were randomized into an experimental and control groups. Relatives of patients from the experimental group received 12 psycho educational, 90 minute sessions about bipolar disorder and coping skills. The caregivers' knowledge of bipolar disorder, the Relationship subscales of the Family Environmental Scale, and the family burden subscales from an adapted version of the Social Behavior Assessment Schedule were assessed before and after intervention. Psycho educated caregivers significantly, improved their knowledge of bipolar disorder and reduced both the subjective burden and the caregivers' belief about the link between the objective burden and the patient. No significant differences were found in the objective burden nor in the family relationship subscales. These preliminary results suggest that psycho educational interventions on caregivers of bipolar patients may improve the caregivers' knowledge of the illness, reduce their, distress or subjective burden and alter their beliefs about the link between the disruptions in their life and the patients' illness.

Murray-Swank, Luckstead, Medoff, Yang, Wohlheiter, and Dixon (2006) conducted the study to characterize the nature of religious and

spiritual support received by family caregivers of persons with serious mental illness and to test the hypotheses that religiosity would be associated with better adjustment, with confounding variables controlled for. Thirty seven percent of the participants reported that they had received spiritual support in coping with their relatives' illness in the previous 3 months. When age, race, education, and gender were controlled for, religiosity was associated with less depression and better self esteem and self care. Personal religiosity was a stronger predictor of adjustment than religious service attendance. Family caregivers of persons with serious mental illness often turn to spirituality for support, and religiosity may be an important contributor to caregiver adjustment. Collaborative partnership between mental health professionals and religious and spiritual communities represent a powerful and culturally sensitive resource for meeting the support needs of family members of persons with serious mental illness.

The majority of people providing informal care for people with amyotrophic lateral sclerosis (ALS) are spouses. Goldstein et al (2006) set out to examine changes in and predictors of psychological distress in spouse carers of people with ALS .Fifty spouse carers of people with ALS underwent an initial interview and at least 21 underwent two further interviews, at median intervals of approximately 5-6 months. They rated the functional impact of their partner's ALS on everyday activities and everyday cognitive, emotional and behavioural changes that might have occurred in the person with ALS. They also rated their own social support and marital relationship, and completed measures of mood, burden and strain. The ALS Severity Scale was also completed for their partner with ALS .Over time, carers' psychological distress (a global measure combining mood, burden and strain) increased significantly. Initially carers' psychological distress was best predicted by the psychosocial impact of their spouse/partners' ALS, the extent to which their partner demonstrated emotional lability and how many other people were considered as dependents of the carer. Subsequently, carer distress was best predicted by an initial measure of negative social

support and by their initial satisfaction with their social relationships. Despite the significant physical impairment associated with ALS, psychosocial factors appear important in determining short- and longer-term psychological well-being in carers of people with ALS and may help clinicians to predict which carers are likely to experience psychological difficulties as part of their caring role.

METHODOLOGY

Sandhya. C. “Stress tolerance, coping styles and well-being of women spouses of mentally ill” Thesis. Department of Psychology , University of Calicut, 2008

Chapter 3

Methodology

- *Design*
- *Sample*
- *Tools*
- *Analysis of data*

Methodology part describes how the investigation was conducted. This part has two purposes: 1) Reading this section, someone should be able to repeat the study exactly in all essential details. 2) Another person should be able to judge the validity and conclusions by comparing them with the method section (McBurney, 2001).

Research Design

Research design is the plan and structure of investigation so conceived as to obtain answers to research questions. The plan is the overall scheme or program of the research. It includes an outline of what the investigator will do from writing the hypotheses and their operational implications to the final analysis of data. A structure is the framework, organization or configuration of elements of the structure related in specified ways (Kerlinger and Lee, 2000). Research plans are deliberately and specifically conceived and executed to bring empirical evidence to bear on the research problem. Research designs set up framework for study of the relations among variables. It tells us in a sense, what observations to make, how to make them, and how to analyze the quantitative representations of the observations (Kerlinger and Lee, 2000). The present study has a non experimental or passive observational design. This design includes neither manipulation of independent variables nor random assignment of participants (Goodwin, 1995). Non experimental research is systematic, empirical inquiry in which the investigator does not have direct control of independent variables because their manifestations have already occurred,

or because they are inherently not manipulable (Kerlinger, 1995).

Aim: - The present study attempts to assess the relationship between the stress tolerance, coping styles, and well being in the female spouses of mentally ill. It also attempts to find out whether the relationship between stress tolerance, coping styles, and wellbeing in the female spouses of mentally ill differ significantly from the male spouses whose wives are mentally ill.

Sample: - The sampling method used in the present study is purposive sampling. Here, a non random (non probability) sample is chosen for some characteristics that it possess (Mc Burney, 2001; Kerlinger, 1995). The sample is characterized by the use of judgment and a deliberate effort to obtain representative samples by including presumably typical areas or groups in the sample (Kerlinger, 1995). Thus spouses of patients suffering from affective disorder and schizophrenia were chosen to be included in the sample.

The sample consisted of two groups: - female spouses whose husbands are mentally ill and male spouses whose wives are mentally ill. The group consisted of 90 males and 90 females whose spouses were diagnosed to have mental illness. The subjects' age ranged between 20-45 years in the case of female spouses whose husbands were mentally ill, their mean age being 32.5. Male spouses whose wives were mentally ill were of the age range 25-45 years, mean age being 35 years. The educational qualification of the subjects ranged from class 10 to graduate degree.

Clear inclusion-exclusion criteria were chalked out.

Inclusion criteria

(a) The spouses of all the subjects were mentally suffered from affective disorder. Both male and female spouses of mentally ill were of the patients who suffered either from manic or depressive phases of the affective disorder.

(b) The spouses who were mentally ill suffered from schizophrenia – paranoid type.

(c) The spouses who were mentally ill had a history of being treated for at least 6 months.

(d) The male and female spouses of the mentally ill were married to their respective partners for at least a year.

(e) The spouses of the mentally ill were parents to at least one child.

Exclusion Criteria

(a) The mental illness in the spouses of the subjects due to drugs, specific organic syndromes or a general medical condition.

(b) The mentally ill spouses of the subjects who were asymptomatic during the period of the study.

The sample was drawn from Manohar Hospital, Calicut. Both the male and female spouses of the mentally ill were drawn from the out patient department and inpatient group of the hospital. The diagnoses of the mental illness of both the genders were made by the psychiatrist according to DSM-1V-TR and ICD – 10 criteria.

The sample included subjects with different demographic characteristics. Tables 3.1 to 3.8 give the distribution of the sample in the different characteristics.

TABLE 3.1

Table for the age-wise distribution of the Sample

Sl. No.	Age Group	Spouses of Patients in Manic phase	Spouses of patients in depressive phase	Spouses of patients with schizophrenia – paranoid type
1	20-30 yrs	21	21	13
2	30-40 yrs	22	21	23
3	40-45 yrs	17	18	24

TABLE 3.2

Table for gender-wise distribution of the sample

Sl. No.	Gender of the sample	Spouses of patients in manic phase	Spouses of patients in depressive phase	Spouses of patients with schizophrenia-paranoid type
1	Male	30	30	30
2	Female	30	30	30

TABLE 3.3

Table for duration of the illness distribution

Sl. No.	Duration of Illness	Spouses of patients in manic phase	Spouses of patients in depressive phase	Spouses of patients with schizophrenia-paranoid type
1	6 months - 1 yr	20	24	23
2	1 yr - 5 yrs	21	23	21
3	5 yrs - 10 yrs	19	13	16

TABLE 3.4

Table for the religion-wise distribution of the sample

Sl. No.	Religion	Spouses of patients in manic phase	Spouses of patients in depressive phase	Spouses of patients with schizophrenia-paranoid type
1	Hindu	23	23	25
2	Christian	9	9	7
3	Muslim	28	28	28

TABLE 3.5

Table for the socio-economic distribution of the sample

Sl. No.	Religion	Spouses of patients in manic phase	Spouses of patients in depressive phase	Spouses of patients with schizophrenia-paranoid type
1	Lower Class	16	6	5
2	Middle Class	25	36	34
3	Upper class	20	18	21

TABLE 3.6

Table for the employment-wise distribution of the sample

Sl. No.	Employment Status	Spouses of patients in manic phase	Spouses of patients in depressive phase	Spouses of patients with Schizophrenia-paranoid type
1	Employed	42	40	42
2	Unemployed	18	20	18

TABLE 3.7

Table for the distribution of the nature of the family of the Sample

Sl. No.	Nature of the family	Spouses of the patients in manic phase	Spouses of the patients in depressive phase	Spouses of the patients with schizophrenia-paranoid type
1	Nuclear family	30	30	25
2	Joint family	30	30	35

TABLE 3.8

Table for the distribution of the duration of marriage

Sl. No.	Duration of the marriage	Spouses of patients in manic phase	Spouses of patients in depressive phase	Spouses of patients with Schizophrenia paranoid type
1	6 mo – 1 year	15	11	18
2	1 yr – 5 yrs	22	21	17
3	5 yrs – 10 yrs	22	29	25

Assessment Tools

Three tools were used to assess the stress tolerance, coping styles and wellbeing respectively.

(a) Life Change Events Inventory

To study the impact of stress, it is necessary to have some yardstick to measure the intensity of the events. Building on the idea that both positive and negative life events could produce stress, Holmes and Rahe developed the Social Readjustment Rating Scale to measure the perceived the stressfulness of 43 life events in1976. By testing thousands of people, they were able to rank a series of life change events in order of their disruptive

impact. Subjects were given the list of events and told that the event of marriage has a value of 50 life change limits. They were then asked to score all the events on a scale from 0 to 100, using the value of 50 for marriage as reference. At the top was the death of a spouse (1000 LCUS) followed by divorce (73 LCUS), imprisonment and death of a close family member (63 LCUS).

A Stressful Life Events Scale for use in India was developed by Singh et al in 1981. It is termed as Presumptive Stressful Events Scale (PSE Scale). There are 24 personal items like divorce, several difficulties, and 27 impersonal items like theft. There are 100 desirable items like getting married, and 32 undesirable items like crops damaged. There are 10 ambiguous events such as prophecy of palmists. (Kuruvila,1991).

The above scale was remodified to suit South Indian culture by Radhakrishnan, Joseph and Varghese in 1984 by adding 14 new items.. This was adapted to Malayalam by Paul and Moorthy in 1992. This Life Change Events Scale consists of 67 items. Each item may or may not have occurred in the subject's life. If it has not, then the subject is required to put him/herself in such a situation and rate the items on a 5 point scale – 5 points for the item that has the potential to induce maximum stress and 1 point for the item that has the potential to induce minimum or no stress at all. How each event is experienced by the subject in fact reveals his/ her stress tolerance. Subjects with higher tolerance for stress rated the statements more in the favor of the left hand side of the 5 point scale. Higher the stress score lower the stress tolerance.

Reliability

The test- retest reliability of LCE scale on a population of 50 subjects was found to be 0.79. The time gap between the first administration and the second administration was a month (Sareena and Anita,2004).

Validity

With respect to the validity, the correlation – coefficient obtained between the LCE scale in Malayalam and LCE scale in English was 0.71 on a population of 50 subjects (Kuruvila,1991).

Administration and Scoring

The Malayalam version of Life Change Events Inventory was administered to both the group of spouses individually. Rapport was established and the instructions were explained clearly as to how to enter the responses. After the subject has rated each statement on a 5 point scale, the scores were totaled together to get the stress tolerance score of the respective subjects. Here it should be noted that the scores of LCI is treated as stress score. That is, higher the scores on LCI, the implication are that the subject's stress tolerance is low and subsequently the stress experienced is higher.

(b) AECOM Coping Scale

Albert Einstein College of Medicine Coping Style questionnaire was developed by Plutchik, Hope and Conte (1989). It is a questionnaire based on psycho evolutionary theory of emotion developed by Plutchik in 1989, which postulates systematic connection between eight basic emotions and eight coping styles. This consists of 87 items, each rated by the subject on a four point scale ranging from 'never to often' weighed from zero to three. It is based on the expressed opinion that the way each individual cope with stressful life events is relatively independent of his/her emotional and psychological sate that is characteristic of him/her.

This model assumes that there are 8 basic coping styles that may be used by an individual in his/her attempt to reduce stress or cope with life problems. Those coping styles as defined by the author are:-

Suppression	Avoiding the problem or the situation.
Succorance	Asking others for help.
Replacement	Dealing with problems of finding alternate solutions.
Blame	Blaming others or the system for his/her problems.
Substitution	Engaging in tension reducing activities like sports.
Mapping	Collecting information about the situation or problems.
Reversal	Acting the opposite of the way he/she feels.
Minimization	Minimizing the importance of the problem or solution.

(c.f, George, 2002)

The adaptation of AECOM to Malayalam was done by and Shanty and Anita (2006).

Reliability and Validity

The initial reliability of AECOM-CSQ is reported to be quite high. Coefficients alphas ranged from +0.62 to 0.83 for the individual scales with an average of +0.70 for the 8 scales. Though the validity of this scale is not mentioned by the author, it was used successfully in a number of studies. In one study, prisoners were found to be lower on the coping styles of Minimization and Replacement and higher on Suppression and Help Seeking than control group (Plutchick and Conte, 1989). In a study of hospitalized alcoholics, they had a strong tendency to use Suppression, Blame and Help Seeking as coping styles in contrast to matched normal controls (Conte, Plutchick, Picard, Galaner, and Jacoby, 1989). Some of the coping styles have also been found to discriminate between violent and non violent sex offenders (Langarin, Lang, Handy, and Majpruz, 1989).Personality and social class differences have also been reported in relation to these coping styles. In a study of academic achievement in

adolescent students, three coping styles –Minimization, suppression and Succorance appeared to be different among High, Average, and Low achievers. High achievers showed a tendency to use Succorance as a coping style. Low achievers tended to Blame others and use Suppression as coping styles (George, 2002). All these studies prove sufficient validity of the scale.

Translation and Standardization

For the use with native population simple and precise Malayalam version of the AECOM-CSQ was prepared (Shanty and Anita, 2006). It was checked by language experts for the equivalence of the meaning. This translated form and the original form were administered to 30 Post graduate students (15 men and 15 women) of various departments of Calicut University. The administration of the forms was done with an interval of 48 hours. The scores of the two forms were correlated using product moment method to estimate reliability. Details of the correlation are given in the table

Reliability of the adapted form of AECOM- CSQ

Coping Styles	Correlation Coefficients
Minimization	0.9480
Suppression	0.9203
Help Seeking	0.9226
Replacement	0.9058
Blame	0.9427
Substitution	0.9581
Mapping	0.8299
Reversal	0.9617

Administration and Scoring

The subjects were seated comfortably and rapport was established. All the instructions were impressed upon the subjects. Each statement was read out to the subjects and their responses were recorded. Doubts if any

were clarified right away.

Each item required a response of NEVER, RARELY, SOMETIMES and OFTEN. Scores of 0, 1, 2, and 3 were assigned for each of the responses respectively. These scores were transferred to the scoring sheet for all the 87 items. There are 8 columns for the 8 subscales. For each column, the scores in that column is added and totaled. This score is then converted to percentile score based on the percentile norms.

(c) PGI General Well being Scale

In 1970, Dr. H. Dubey developed a General Well being schedule. This scale was a 25 item, six point scale with 33 scores measuring several aspects of adjustment like freedom, health, concern, worry, distress, energy level, satisfaction, cheerfulness, relaxation, emotional behavior control, etc. This scale was considered likely to be useful in a variety of research and applied settings such as quality of life index, a mental health status appraisal, a measure of psychotherapy outcome evaluation and as a social indicator of measuring population changes in sense of wellbeing outcome.

This scale was tried out and modified to suit Indian conditions, where the majority of the clinical population is rural, illiterate and unsophisticated in the case of complex tests. Certain items in the scale were deleted and format was changed and simplified. A twenty item scale was thus constituted, which was called PGI General Wellbeing Scale. Items were tested through 'thinking aloud' method for suitability. Its difficulty level was judged by 'underlining test' and was found to be quite low and highly satisfactory. The scale was adapted to Malayalam by Serena and Anita (2004). This PGI General Wellbeing Scale consists of twenty items which are statements pertaining to the emotional state of the individual assessed as it was in the period of a month's time.

Reliability and Validity

Verma and Verma (1989) have cited that reliability estimated by Kuder and Richardson Formula -20 was 0.98 (p<o.o1) and for test retest reliability, the coefficient was 0.91 (p<0.01) for the English version.

The test was correlated with a number of tests in different studies. The scale showed significant correlations of 0.56 with Bradbury wellbeing scale of 0.54 with PGI Quality of life scale (Verma and Verma, 1989).

Administration and Scoring

The subject was seated comfortably and a rapport was established. The instructions were carefully delivered to the subject in detail. The response of the subject to each statement was carefully recorded as a tick mark against the statement. Doubts regarding any of the statement were clarified then and there.

Number of tick marks was counted and that constituted the wellbeing score of that particular individual at that time. Subjects who got more than 10 points on this scale can be considered healthy (Rema, 1995).

d) Information Schedule

An Information schedule prepared by the investigator was given to the participants to note the other variables which would come into play. The information schedule contained information regarding the age, gender, nature of the family, current phase of the illness, duration of marriage, chronicity of the illness, socioeconomic status and religion of the subjects. All the relevant information was duly recorded in the information schedule.

Analysis

The present study is proposed in view of the hypotheses the difference in stress tolerance, wellbeing and coping styles in the wives of mentally ill, and in the husbands whose wives are mentally ill. The study also

aims to examine the relationship between the stress tolerance, wellbeing and coping styles in the female spouses of mentally ill. For this, different hypotheses were formulated and the tenability of the hypotheses was tested statistically as follows:-

After scoring the responses on each test, the means and the standard deviations of the scores on all the three tests (Life Change Events Inventory, AECOM coping Scale, and PGI General Wellbeing Scale) were found separately for the two groups.

- The first hypothesis states that stress tolerance of the female spouses whose husbands are mentally ill differ from the male spouses whose wives are mentally ill was tested using Analysis of variance, ANOVA, for each factor between the scores of men and women. This is also an ideal inferential statistical tool for analyzing the results since the dependent variables (stress tolerance, coping styles and wellbeing respectively) are measured on interval and ordinal scales.

  A two way ANOVA was conducted on stress tolerance by disorders between genders.

  Inter group differences were estimated using Scheffe's method, means, and standard deviations.

- The second hypothesis states that wellbeing of the female spouses whose husbands are mentally ill differ from the male spouses whose wives are mentally ill was tested using

  1. A two way ANOVA for each coping styles by gender and disorders between the female and male spouses.

  2. Inter group differences were further clarified through means, standard deviations, and Scheffe's method.

  3. One way ANOVA and t were used to analyze the influence of the age, gender, area of domicile, nature of the family, duration of the

marriage, chronicity of the illness, socioeconomic status, and the religion of the subjects on the coping styles.

- The third hypothesis states that women whose husbands are mentally ill differ from men whose wives are mentally ill in terms of coping styles. This was tested using

  1. A two way ANOVA for wellbeing by gender and disorder between the female and male spouses

  2. Inter group differences were further classified through Scheffe's method, means and standard deviations.

  3. One way ANOVA and t were used to analyze the influence of the age, gender, area of domicile, nature of the family, duration of marriage, chronicity of the illness, socioeconomic status, and religion of the subjects on wellbeing.

- The fourth hypothesis states that stress tolerance and wellbeing are related. This relationship is further explored gender wise in the two sub hypothesis namely

  a) Stress tolerance and wellbeing are related in the female spouses.

  b) Stress tolerance and wellbeing are related in the male spouses.

  Product moment correlation method was used to find out the relationship of the variables in the genders.

- The fifth hypothesis states that coping styles and wellbeing are related. This relationship is further explored gender wise in the two sub hypothesis namely

  a) Coping styles and wellbeing are related in the female spouses.

  b) Coping styles and wellbeing are related in the male spouses.

  These hypotheses were tested using product moment correlation.

- The sixth hypothesis studies the predictive value of coping styles and stress tolerance on wellbeing. The two sub hypotheses states that

  a) Different coping styles and wellbeing can be used to predict the stress tolerance in the female spouses.

  b) Different coping styles and wellbeing can be used to predict the stress tolerance in the male spouses.

  These hypotheses were studied using stepwise multiple regressions.

- The seventh hypothesis studies the predictive value of coping styles and wellbeing on stress tolerance. The two sub hypotheses states that

  a) Different coping styles and stress tolerance can be used to predict the well being in the female spouses.

  b) Different coping styles and stress tolerance can be used to predict the wellbeing in the male spouses.

  Step wise multiple regression were used to verify these hypotheses.

  The results and discussions are presented in the next chapter.

RESULTS AND DISCUSSION

Sandhya. C. “Stress tolerance, coping styles and well-being of women spouses of mentally ill” Thesis. Department of Psychology , University of Calicut, 2008

Chapter 4

Results and Discussion

- Two way ANOVA
- Product moment correlation
- Multiple regression analysis (stepwise)
- 't' test analysis
- One way ANOVA

In the present study, an attempt has been made to understand stress tolerance, coping styles and well being of the female spouses of the mentally ill. The results obtained in the study are divided into three sections. In the first section, results regarding the differences in the male and female spouses on the stress tolerance coping styles and well being are dealt with. The second section deals with the results pertaining to the relationship between stress tolerance, coping styles and wellbeing in both the genders. The third section deals with the predictability of one dependent variable in lieu with the other two.

SECTION 1

This section verifies the first three hypotheses of the study.

HYPOTHESIS 1

With respect to the first hypothesis, stress tolerance of the female and male spouses, and the gender wise differences were found out. A two way ANOVA was computed to find out the independent effects and interaction effects of gender (male spouses and female spouses) and disorders (mania, schizophrenia – paranoid type, and depression) on stress tolerance, wellbeing, and coping styles. ANOVA will generate a significance value indicating whether there is significant difference within the comparisons being made. This significance value does not indicate where the differences is or what the differences are, but a Scheffe's test can identify which group differ significantly from each other.

Table 4.1 contains the mean and standard deviation of the gender on stress.

TABLE 4.1

Mean and Standard Deviation for the Effect of Gender on Stress

Dependent Variable	Gender			
	Females (N = 90)		Males (N = 90)	
	X	σ	X	σ
Stress tolerance (Stress Scores)	252.99	38.91	225.29	44.5

From the mean values of the gender on stress tolerance depicted in Table 4.1, it can be seen that the female spouses of the mentally ill suffers higher levels of stress (252.99) than compared with their male counterparts (225.29).

Table 4.2 contains the means and standard deviations of the disorders on stress.

TABLE 4.2

Mean and Standard Deviation for the effect of disorders (mania, schizophrenia-paranoid type, depression) on stress tolerance

Dependent Variable	Disorder					
	Mania (N=60)		Schizophrenia (paranoid) (N=60)		Depression (N=60)	
	X	σ	X	σ	X	σ
Stress tolerance (Stress scores)	223.10	33.16	277.66	30.97	216.65	38.83

From Table 4.2, which contains the mean value of the effects of disorders on stress, it could be seen that, of the three disorders schizophrenia of the paranoid type contributes most to the stress of the spouses (277.66) irrespective of the gender. Of the three disorders depression contributes least to the stress of the spouses (216.65).

Table 4.3 contains the means and standard deviations of the interaction of gender and disorder on stress tolerance.

TABLE 4.3

Table showing the Mean and Standard Deviation for the effect of interaction of gender and disorders on stress tolerance

Variables		Females (N=90)			Males (N=90)		
		Disorders			Disorders		
		Mania (N=30)	Schizo-phrenia (Paranoid) (N=30)	Depre-ssion (N=30)	Mania (N=30)	Schizo-phrenia (Paranoid) (N=30)	Depre-ssion (N=30)
Stress & tolerance (stress scores)	X	234.87	285.77	238.83	211.33	269.57	194.97
	σ	33.24	25.30	35.03	29.1	34.3	29.47

Table 4.3 shows the mean values and standard deviations of the disorders on stress tolerance of the female and male spouses suffering from mania, schizophrenia – paranoid type, and depression. It is seen that the female spouses of the patients with paranoid schizophrenia experiences higher stress (285.77) than their male counterparts (269.57).

Table 4.4 contains the result of Two-way ANOVA of stress for gender, disorder, and their interaction effect.

TABLE 4.4

Result of the Two-way ANOVA of Stress Tolerance for Different Levels of Gender and Disorders

Variables	Residual		Gender			Gender			Gender x Disorder		
	Sum of squares	Mean of squares	Sum of squares	Mean of squares	F	Sum of squares	Mean of squares	F	Sum of squares	Mean of squares	F
Stress tolerance (stress scores)	170050.5	977.30	34528.05	34528.05	35.33**	134843.14	67421.57	68.98***	5925.83	2962.91	3.03*

* P<0.05, ** P<0.01, *** P<0.001

From the F values depicted in Table 4.4 it can be seen that the male and female spouses of mentally ill differ in their stress tolerance (F=35.33). Women undergo a lot of stress due to their caretaker role in addition to the several of the multiple roles they have. When their spouses suffer from paranoid schizophrenia which has the worst prognosis when compared to that of the affective disorders, the toll it takes on the wives become manifold. Most of the paranoid schizophrenics also harbor delusions of infidelity, which can add to the stress experienced by the wife.

From the table it could be seen that there is a highly significant difference in the stress tolerance when it comes to the effect of disorders (68.98). Scheffe's Test was used to identify which groups differ from each other. Table 4.5 portrays the difference between the disease groups for stress.

TABLE 4.5

Scheffe's F for Stress Tolerance between different disease (Mania, Schizophrenia, Paranoid type, Depression) groups

Group	Mean	F
Mania (N=60)	223.1	56.69**
Schizophrenia (Paranoid) (N=60)	277.6	
Depression (N=60)	216.65	

* P<0.05, ** P<0.01, *** P<0.001

From the Scheffe's F, it can be seen that patients suffering from paranoid schizophrenia imposes greater amount of stress on their spouses irrespective of the gender. Values on schizophrenia differ significantly from the other two illness group. Schizophrenia, paranoid type is a continuous illness, where the compliance of the patient is very poor. Also this illness is more prone to frequent relapses due to the poor compliance. Since the patient attains insight very late in the therapy, constant monitoring is needed where the compliance is concerned. Thus the spouse is required to be

vigilant constantly, which could contribute significantly to the stress experienced.

HYPOTHESIS 2

The second hypothesis states that the wellbeing of the female and male spouses of the mentally ill will differ. To verify this hypothesis ANOVA was used. To find out the exact nature of the difference Scheffe's test was employed. Means and the standard differences for the effect of gender on wellbeing are portrayed in Table 4.6.

TABLE 4.6

Table showing Mean and Standard Deviation for the effect of Gender on Well-being

Dependent Variable	Gender			
	Females (N=90)		Males (N=90)	
	X	σ	X	σ
Well being	7.41	3.81	9.21	4.61

From the mean values depicted in the Table it can be seen that the sense of wellbeing enjoyed by the female spouses of the mentally ill is poor (7.41) when compared to that of the wellbeing of male spouses of the mentally ill (9.21) which logically fits into the pattern i.e. higher the levels of stress, lower the sense of wellbeing.

Table 4.7 shows the means and standard deviations of the effect of the disorders on wellbeing.

TABLE 4.7

Table showing Means and Standard Deviations for the Effect of Disorder (Mania, Schizophrenia-paranoid type, Depression) on Well being

Dependent Variable	Disorder					
	Mania (N=60)		Schizophrenia-paranoid type (N=60)		Depression (N=60)	
	X	σ	X	σ	X	σ
Well being	9.01	4.71	5.81	2.43	10.1	4.26

It can be seen from the Table that irrespective of gender sense of wellbeing enjoyed by the spouses of the paranoid schizophrenics is very poor (5.81). This is in agreement with the implication of the values of the Table 4.2.

Table 4.8 contains the means and standard deviations of the effect of gender and disorder on wellbeing.

TABLE 4.8

Table showing the Means and Standard Deviations for the effect of Interaction of Gender and Disorder on Well being

	Females (N=90)			Males (N=90)		
	Disorders			Disorders		
	Mania (N=30)	Schizo-phrenia (N=30)	Depre-ssion (N=30)	Mania (N=30)	Schizo-phrenia (N=30)	Depre-ssion (N=30)
X	8.46	5.53	8.23	9.56	6.10	11.96
σ	4.98	1.87	3.28	4.44	2.89	4.36

As seen from the Table, and in consensus with the values of Tables 4.4, it is the female spouses of paranoid schizophrenics who enjoy the least sense of wellbeing (5.53) than the male spouses of the paranoid schizophrenics (6.10).

Table 4.9 contains the result of the Two-way ANOVA of wellbeing.

TABLE 4.9

Result of the Two-way ANOVA of Well being for Different Levels of Gender and Disorder

Variables	Residual		Gender			Gender			Gender x Disorder		
	Sum of squares	Mean of squares	Sum of squares	Mean of squares	F	Sum of squares	Mean of squares	F	Sum of squares	Mean of squares	F
Well being	2503.33	14.38	145.8	145.8	10.13**	595.21	297.60	20.68***	86.23	43.11	2.99*

* P<0.05, ** P<0.01, *** P<0.001

From the F value of Table 4.9, it can be seen that there is a significant gender difference in wellbeing (10.13). When their spouses fall mentally sick, it is the females who suffer more from decreased sense of wellbeing. Here too like stress, multiple roles and the added on effect of having her husband mentally ill could be the reason why the female spouses suffer from lowered sense of wellbeing. As depicted in the Table 4.8, it is evident that paranoid schizophrenia of their husbands takes a definite toll on the wellbeing of the female spouses. Apart from the all too understandable difficulties of the positive and negative symptoms of paranoid schizophrenia, the most severe of the positive symptoms will be when the delusions involve themes of infidelity. The perception of the spouses that the touchstone of the relationship – trust – is gone could considerably lower the sense of wellbeing. This is true for both the genders. However it is the female spouses of the paranoid schizophrenics who show decreased sense of wellbeing than their male counter parts.

Scheffe's F was done to estimate the exact difference and the results are depicted in Table 4.10.

TABLE 4.10

Scheffe's F for Well being between Different Disease (Mania, Schizophrenia-paranoid, Depression) groups

Group	Mean	F
Mania (N=60)	9.01	19.25***
Depression (N=60)	10.10	
Schizophrenia (Paranoid type) (N=60)	5.81	

* P<0.05, ** P<0.01, *** P<0.001

From the F value, it can be seen that spouses of patients with depression enjoy more wellbeing than the spouses of patients with mania or paranoid schizophrenia. It can also be seen that spouses of patients with paranoid schizophrenia enjoy the least wellbeing of the three illness group.

Depression when compared to schizophrenia causes less impairment in terms of marital harmony. Also depression responds well to treatment both in terms of compliance and prognosis, while the patients with paranoid schizophrenia often show alarming tendencies of poor compliance. Also patients with depression often exhibit a better insight into their problem, whereas it takes a very long time for patients with paranoid schizophrenia to be insightful. Thus all these add to the stress of the spouse of the patients with paranoid schizophrenia and thus the wellbeing experienced is less.

HYPOTHESIS 3

The third hypothesis states that coping styles of the female spouses whose husbands are mentally ill differ from the male spouses whose wives are mentally ill. To verify this hypothesis Two-way ANOVA was used. F values of the interaction are depicted in Table 4.11.

TABLE 4.11

Result of the Two-way ANOVA of the Effect of Different Levels of Gender and Disorder on Coping Styles

Variables	Residual		Gender			Gender			Gender x Disorder		
	Sum of squares	Mean of squares	Sum of squares	Mean of squares	F	Sum of squares	Mean of squares	F	Sum of squares	Mean of squares	F
Minimization (CS_1)	126737.56	728.37	12086.80	12086.80	16.59***	4601.37	2300.68	3.15*	16454.57	8227.28	11.29***
Suppression (CS_2)	95950.10	551.437	23.47	23.47	0.43	3584.87	1792.43	3.25*	2971.21	1248.60	2.26*
Succorance (CS_3)	93638.70	538.15	1798.67	1798.67	3.34	11112.87	5556.43	10.32***	3421.81	1710.90	3.17*
Replacement (CS_4)	128673.0	739.5	38368.80	38368.80	51.88***	2275.24	1137.62	1.53	1513.2	756.60	1.02
Blame (CS_5)	116881.70	671.73	13537.33	13537.33	20.15***	18168.04	9084.02	13.52***	3924.44	1962.22	2.92
Substitution (CS_6)	102690.06	590.17	2508.80	25078.80	4.25*	21215.54	10607.77	17.97***	42159.90	21079.95	35.71***
Mapping (CS_7)	117518.16	675.39	6882.05	6882.05	10.19**	11475.87	5737.93	8.49***	11068.23	5534.11	8.19***
Reversal (CS_8)	146028.16	839.24	19034.45	19034.45	22.68***	3735.54	1867.77	2.22	713.23	357.61	0.426

* P<0.05, ** P<0.01, *** P<0.001

From the F values it can be seen that the coping style minimization differs significantly in the terms of gender (16.59), in terms of disorder (3.15), and in terms of the interaction effect of gender and disorder (11.29). Coping style suppression differs significantly only in terms of disorder (3.25), and the interaction effect (2.26). In the case of the coping style succorance also, the significant difference is seen only on the effect of disorder (10.32) and the interaction effects (3.17). The fourth coping style replacement is significant only in terms of gender (51.88)

Blame, the fifth coping style is significantly different both in terms of the gender (20.15) and disorder (13.52). Substitution shows significant differences in terms of the effect of gender (4.25), disorder (17.97) and the interaction effect of the both (35.71). Mapping also shows significant difference in terms of gender (10.91), disorder (8.49) and the interaction effect (8.19). Finally, reversal shows significant difference only on the effect of gender (22.68).

The mean values and standard deviations of the effects of gender on coping styles are depicted in Table 4.12.

TABLE 4.12

The Means and Standard Deviations for the Gender Groups on Coping Styles

Dependent Variables	Gender			
	Females (N=90)		Males (N=90)	
	X	σ	X	σ
Minimization (CS_1)	43.24	29.51	59.63	28.09
Suppression (CS_2)	52.53	25.57	51.81	22.18
Succorance (CS_3)	55.76	25.07	72.08	24.21
Replacement (CS_4)	28.14	26.92	57.34	27.63
Blame (CS_5)	40.68	28.75	58.03	27.10
Substitution (CS_6)	46.55	33.25	39.08	27.56
Mapping (CS_7)	53.47	32.82	65.84	22.27
Reversal (CS_8)	33.51	29.62	54.07	28.51

The coping styles minimization is found to be used more by the male spouses of the mentally ill (CS1-59.63) than it is used by the female spouses. It could be found that the female spouses of the mentally ill employs the coping style of suppression slightly higher (CS2-52.53) than the frequency of the same used by the male spouses (51.81). It is interesting to note that male spouses use succorance more (72.08) than the female spouses (55.76) and than any of the other coping styles. It is seen from the mean values that female spouses extensively employs the coping style of substitution (CS6 – 46.55) more than the male spouses (39.08). Coping styles of replacement and reversal (CS4 and CS8) are employed more by the male spouses (57.34) and (54.07) respectively. Female spouses employ these coping styles sparingly when compared with that of male spouses of the mentally ill (28.14) and (33.51) respectively. It is also noteworthy that male spouses of the mentally ill tend to use the coping styles blame and mapping (CS5 and CS7) more (58.03 and 65.84) when compared with the female spouses (40.68 and 53.47).

Table 4.13 consists of the mean values of the effects of disorder on the coping styles employed by the spouses irrespective of their genders.

TABLE 4.13

The Means and Standard Deviations for the effect of Disorders (Mania, Schizophrenia-Paranoid type and Depression) on the Coping Styles

Dependent Variables	Disorder					
	Mania (N=60)		Schizophrenia Paranoid type (N=60)		Depression (N=60)	
	X	σ	X	σ	X	σ
Minimization (CS_1)	47.61	26.35	48.11	30.35	58.58	31.87
Suppression (CS_2)	52.50	22.79	46.55	25.65	57.46	22.16
Succorance (CS_3)	65.70	23.51	79.75	17.49	61.33	28.57
Replacement (CS_4)	46.13	31.44	44.26	27.13	37.83	33.64
Blame (CS_5)	51.35	27.13	60.55	27.98	36.18	27.52
Substitution (CS_6)	41.95	26.10	56.53	30.85	29.98	29.39
Mapping (CS_7)	66.31	23.04	48.43	30.75	64.23	28.62
Reversal (CS_8)	39.28	28.72	50.03	30.63	42.06	32.34

Spouses of patients with depression employ the coping styles minimization (CS1) and suppression (CS2) most (58.58 and 57.46 respectively). However, spouses of patients with paranoid schizophrenia use suppression less (46.55). They use succorance (CS3) as a coping style more than the spouses of patients with mania or depression. (79.75). The coping style replacement (CS4) is used more by the spouses of manics (46.13) followed by paranoid schizophrenics (44.26).Blame (CS5) is employed more by the spouses of paranoid schizophrenics (60.55). Spouses of the depressives use this coping style least (36.18). Substitution (CS6) is the least used coping style by the spouses of depressives (29.98) when compared with the spouses of patients with paranoid schizophrenia (56.53) or mania (41.95). The spouses of the patients in manic episode employs mapping (CS7) more (66.31) than the spouses of the patients of the other two groups. It is used less by the spouses of the patients with paranoid

schizophrenia. The coping style reversal (CS8) is most used by the spouses of the patients suffering from paranoid schizophrenia (50.03) and least used in the spouses of patients who are manics (39.28).

Table 4.14 consists of the mean values of the effects of gender and disorder on the eight coping styles.

TABLE 4.14

Table showing the Means and Standard Deviations for effects of Gender and Disorder on Coping Styles

Dependent Variables		Females			Males		
		Disorders			Disorders		
		Mania (N=30)	Schizophrenia (N=30)	Depression (N=30)	Mania (N=30)	Schizophrenia (N=30)	Depression (N=30)
Minimization (CS_1)	X	51.40	28.50	49.83	43.83	67.73	67.33
	σ	26.98	22.29	33.31	25.59	24.11	28.24
Suppression (CS_2)	X	49.76	44.76	63.06	55.23	48.33	51.86
	σ	24.37	23.82	25.70	21.15	27.66	16.53
Succorance (CS_3)	X	63.00	71.03	63.26	68.40	88.46	59.40
	σ	25.87	19.72	28.78	20.99	8.72	28.71
Replacement (CS_4)	X	31.63	26.06	26.73	60.63	62.46	48.93
	σ	33.13	18.79	27.45	21.85	21.42	35.97
Blame (CS_5)	X	36.56	57.10	28.40	66.13	64.00	43.96
	σ	24.81	31.22	22.24	20.74	24.36	30.34
Substitution (CS_6)	X	29.63	80.86	29.16	54.26	32.20	30.80
	σ	23.42	17.91	26.452	22.87	19.77	32.53
Mapping (CS_7)	X	71.16	35.76	53.50	61.46	61.10	74.95
	σ	23.14	31.38	33.73	22.26	24.63	17.04
Reversal (CS_8)	X	28.60	42.36	29.56	49.96	57.70	54.56
	σ	27.11	31.82	29.69	26.58	27.83	31.33

Minimization as a coping style is employed most by the female spouses of the patients with mania (51.40). It is used least by the female spouses of patients with paranoid schizophrenia (28.50). Male spouses of patients with mania use minimization least (43.83) and husbands of wives with paranoid schizophrenia use this coping style most (67.73). Suppression is used mostly by the female spouses of the patients with depression (63.06).Wives and husbands of patients with paranoid schizophrenia uses it the least (44.76 and 48.33 respectively). Husbands of patients with mania use suppression most (55.23). Female and male spouses of patients with paranoid schizophrenia employ succorance most (71.03 and 88.46 respectively). Wives of husbands with mania employ succorance least (63.00) and the husbands of the wives with depression employ the same least (59.40). Wives with husbands having paranoid schizophrenics use replacement least (26.06) and wives with husbands in manic phase use replacement most (31.63). Male spouses with wives who are depressives use replacement least (48.93) and they employ replacement most when their wives have paranoid schizophrenia (62.46).Blame as a coping style is used mostly by wives whose husbands suffer from paranoid schizophrenia (57.10). They use it least when their husbands are suffering from depression (28.40). Husbands use blame mostly when their wives suffer from mania (66.13) and least when their wives suffer from depression (43.96). Substitution is the most used coping style of female spouses of the patients with paranoid schizophrenia (80.86). Husbands with wives who have mania are found to use this coping style more (54.26). Both the females and males use this coping style least when their spouses suffer from depression (29.16 and 30.80 respectively). Wives with husbands who have mania use mapping most (71.16). They employ this coping style least in paranoid schizophrenia (35.76). Male spouses use mapping more when their wives suffer from depression (74.96). They use it least when their wives suffer from paranoid schizophrenia (61.10). Reversal is used most by female spouses of husbands with paranoid schizophrenia (42.36). They use it least when their

husbands suffer from mania (28.60). Male spouses with wives of paranoid schizophrenia use this coping style more (57.70). As in their male counterparts, male spouses use this coping style least when their spouse suffers from mania (49.96).

Where the coping style minimization is concerned, from the mean values of Table 4.14, it can be seen that both the genders differ significantly in terms of this coping style. Disorders of the spouses also vary significantly in which minimization is employed. Minimization involves minimizing the importance of the problem. Where the female spouses are concerned, since they would be aware of the recurrent nature and self evident symptoms of mania, they would always go for an early intervention. This would stop the flaring up of mania and thus minimize the importance of the problem. The male spouses of the paranoid schizophrenics are seen to employ this coping style more. Here maybe the chronicity of the disease plays an important role. Also commonly arising problems in the intervention of paranoid schizophrenia is the poor level of compliance, which will often account to the frequent relapses. The male spouses maybe using this coping style to insulate themselves by reducing the importance of the problem. May be, the male spouses find it stressful to make the house functional in the psychological absence of their wives for which they are ill equipped. This also could be another reason why male spouses engage in this coping style more.

As seen from Table 4.14, the female spouses of husbands with depression employs suppression more (63.06), while the male spouses of wives with mania employ this coping style more (55.23). Suppression is the coping style where the problem or the situation is avoided. When husband has depressive illness, the major fall outs are the negative cognitions, non availability of the spouse psychologically, and lack of activity bordering on refusal to go for work. Here suppression may be employed by the female spouse as a reflection of their own psychological tiredness and their inability

to change the situation or illness. Likewise, when the wives are affected with mania, the whole family is thrown out of gear. The disinhibition often exhibited by the wives in the manic phase becomes a source of embarrassment and distress. It would be easier for the male spouses if they avoid or ignore the problem. Thus male spouses may employ suppression as a coping style. Apart from this, in our culture, males are not equipped with enough of skills to run a household. For many of the basic aspects of living – from laundry to food – they are dependent on females. So, the sudden inability from the part of the female spouses to acquiesce with all these basic aspects could prompt at least some of the males to adopt suppression as a means to cope with the situation.

The exact nature of the difference in the use of suppression in the three disease group was estimated using Scheffe's test, and the results are shown in Table 4.15.

TABLE 4.15

Scheffe's F for the Coping Style Suppression between different disease (Mania, Schizophrenia-paranoid type, Depression) groups

Group	Mean	F
Mania (N = 60)	52.50	3.22*
Schizophrenia (Paranoid) (N=60)	46.55	
Depression (N = 60)	57.46	

* P<0.05, ** P<0.01, *** P<0.001

Table 4.15 speaks of the difference in the usage of coping style suppression in the three disease groups. From the mean values it is evident that the spouses of patients with depression use this coping style more than the spouses of patients with mania or paranoid schizophrenia. It is also seen that spouses of patients with paranoid schizophrenia engage this coping style less frequently than the other two groups. At least at times, the spouses of depressives can afford to avoid the problem because of the relatively easy

remission and the insightfulness of the patients. Thus the spouses of depressives can at least at times avoid the problem/situation as a means of taking a psychological break or investing their energy and time on other issues.

From Table 4.11 it can be seen that there is no significant difference in the case of gender where the coping style succorance is concerned. However there is a highly significant difference in the case of different disorders (mania, paranoid schizophrenia and depression). Mean values depicted in Table 4.12 shows that male spouses of the mentally ill this coping style more (72.08). Table 4.13 shows that irrespective of their genders, spouses employ succorance when their spouses have paranoid schizophrenia. Mean values of Table 4.14 shows that male spouses of wives with paranoid schizophrenia uses succorance more (88.46) than their female counterparts (71.03). The male spouses, when they have to take care of their homes and children and employ themselves at work simultaneously, often would naturally seek out help to function effectively. In the sample taken, most of the female spouses belong to non working class. This may spare them time and energy for attending to their homes, sick husband and children. Apart from this explanation, females in our socio cultural milieu are expected to cope with stress, and consciously and unconsciously, family and society molds females to be hardier in the face of stress. Their help seeking will largely be confined to monetary aspects and occasionally to human aspects, while the vice versa will be true for male spouses. They would need human resources more than the monetary aspects. Poor compliance from the patients' part and frequent relapses of the illness may prompt both the sexes to use this coping style more.

Table 4.16, which contains the result of Scheffe's test examines the exact nature of the difference in the usage of the coping style succorance in the three disease groups.

TABLE 4.16

Scheffe's F for the Coping Style succorance between different disease (Mania, Schizophrenia-paranoid type, Depression) groups

Group	Mean	F
Mania (N = 60)	65.70	9.94**
Schizophrenia (Paranoid) (N=60)	79.75	
Depression (N = 60)	61.3	

* P<0.05, ** P<0.01, *** P<0.001

Table 4.16 consists of the Scheffe's F for the coping style succorance between the spouses of patients with the mental illnesses. Succorance or help seeking is more employed by the spouses of patients suffering from paranoid schizophrenia, as seen from the F values. The resistance of the disease to treatment, poor compliance, the strained interpersonal relationships, and often the violent nature of the illness drives the spouse to actively seek out resources for professional help and other kinds of support. The usage of this coping style is justified because of its high practical value and it being a positive coping style.

Table 4.11 shows that there is a significant difference between the sexes in the usage of the coping style replacement (F=51.88). Replacement is the coping style where alternate solution to the problem is generated. Mean values of gender in Table 4.12 shows that male spouses adopt this coping style more (57.34) than the female spouses (28.14). Among the disorders, this coping style is more used in manic episodes of the spouses (46.13), and male spouses of the patients with paranoid schizophrenia uses it more (62.46) than the male spouses of patients with affective disorder and their female counterparts. Female spouses use this coping style more when their husbands suffer from mania (36.56). Paranoid schizophrenia of the female spouse calls for urgent dealing with the problem and finding an alternate solution because of the bizarre delusional systems and hallucinations. Also it is imperative that the female of the house be whole

again, because the wellbeing of the family largely depends upon her. Female spouses, however use this coping style more when their husbands suffer from mania. The comparatively sudden manifestations of the symptoms of mania and its relatively quick remission may be factors that encourage the female spouse to use the coping style replacement.

There is significant difference in the ways the two genders employ the coping style blame, and in the ways the disorders generate this coping style as is evident from the Table 4.11. From the mean values of Table 4.12, it is seen that blame is used more by male spouses (58.03). Paranoid schizophrenia generates this coping style more than the affective disorders (60.55) as depicted in the Table 4.13,and the Table 4.14 shows that male spouses of manics blame more (66.63), while the wives of the patients with paranoid schizophrenia uses blame more (57.10). Blame is blaming others or the system for his/her problems. With people of less psychological awareness it is quite common to blame the patient or his situations for the symptoms of mania like increased irritability, disinhibitted behavior, extravagance and interpersonal difficulties during the period of illness. When wife is in the manic phase of the affective disorder, unlike in that of depressive phase, expressed emotions of the husbands tend to be higher and subsequently, they tend to use blame as a coping style to deal with the stress of the situation.

Having a spouse who has schizophrenia itself poses a lot of challenge and distress. Often the wife is subjected to verbal and physical abuse. Apart from these obvious stressors, when the delusional system is full of themes of infidelity, it often places wife under minute scrutiny which adds to the stress. Blame may be used by the wives of the patients with paranoid schizophrenia to salvage her perceived decline of integrity and virtue. Sometimes the blame is placed upon the patient, and at other times 'destiny' or 'fate' is blamed.

The exact nature of the difference in the employment of the coping style blame is shown in the Table 4.17.

TABLE 4.17

Scheffe's F for the Coping Style Blame between different disease (Mania, Schizophrenia-paranoid type, Depression) groups

Group	Mean	F
Mania (N = 60)	51.35	11.96***
Schizophrenia (Paranoid) (N=60)	60.55	
Depression (N = 60)	36.18	

* P<0.05, ** P<0.01, *** P<0.001

The Table 4.17 shows Scheffe's F value for the coping style blame in the spouses of the mentally ill. It can be seen that there is a high significant difference between the spouses of paranoid schizophrenics and those of with mania. Blame a dysfunctional coping style is seemed to be used more when the spouses suffer from paranoid schizophrenia. They because of their high levels of stress experienced and poor quality of life tends to engage blame. Blame may be used as a means to reduce their stress by active vocalization of their distress and target the illness and other related factors as a reason for their distress.

From Table 4.17 it can be seen that both the genders differ significantly in the use of the coping style substitution. Likewise there is significant difference among the disorders where the use of substitution is concerned. Also, both the genders and disorders differ significantly in the use of substitution. From the mean values of the Table 4.12, it can be seen that females employ substitution more (46.55) than their male counterparts (39.08). Table 4.13 shows that the spouses of the patients with paranoid schizophrenia employ substitution as a coping style (56.53). From Table 4.14 it is obvious that female spouses of paranoid schizophrenics use substitution more (80.86). In the case of male spouses, this coping style is

more employed when their wives have mania (54.26). Substitution is engaging in tension reducing activities. Female spouses of the patients with paranoid schizophrenia have a great deal of stress to face and their need to find other avenues for tension release is quite high. This is true for male spouses as well. Both the spouses has to come to terms with the psychological non- availability of their respective spouses, added responsibility of treatment and care taking, and maintaining some amount of normalcy at home. For achieving all these it requires the partners to employ substitution.

Table 4.18 depicts the Scheffe's F value on the employment of the coping style substitution.

TABLE 4.18

Scheffe's F value for the Coping Style substitution between different disease (Mania, Schizophrenia-paranoid type, Depression) groups

Group	Mean	F
Mania (N = 60)	41.95	12.74***
Schizophrenia (Paranoid) (N=60)	56.53	
Depression (N = 60)	29.98	

* P<0.05, ** P<0.01, *** P<0.001

It is seen that the coping style substitution is used more by the spouses of patients suffering from paranoid schizophrenia. Paranoid schizophrenia is difficult to remit and often the prognosis is not very good, while mania goes into remission fast and has a good prognosis. Poor level of compliance and frequent relapses are stressors that have to be handled. In the face of heightened stress it becomes essential that the spouses engage in some kind of tension reducing activities.

There is significant difference between the genders and among various disorders in the usage of the coping style mapping as is evident from the Table 4.11. From Table 4.12 it can be seen that male spouses use

mapping more (65.84) than the female spouses (53.47). Mapping is employed by the female spouses and the male spouses in the cases where their partners suffer from mania and depression as seen from Table 4.14 (71.16 and 74.96 respectively). Mapping is collecting information about the problem or solution. Often, many of the caretakers of the spouses with mania, at first react to the changes in their spouses' affect with bafflement, resentment and anger. It is only later it dawns on them that the change in affect signifies a major disorder. From this point onwards mapping is employed to seek more information about the problem and the subsequent solution. In the case of husbands whose wives are depressives, the sudden destabilizing that occurs in the family due to the withdrawal of the wives and because of the risk of deliberate self harm, mapping is employed by the male spouses. Mapping is important to both the patients' and their spouses' life and wellbeing. The exact nature of the difference is verified using Scheffe's test and the results are shown in Table 4.19.

TABLE 4.19

Scheffe's F value for the Coping Style Mapping between different disease (Mania, Schizophrenia-paranoid type, Depression) groups

Group	Mean	F
Mania (N = 60)	66.31	7.49**
Schizophrenia (Paranoid) (N=60)	48.43	
Depression (N = 60)	64.23	

* P<0.05, ** P<0.01, *** P<0.001

From the F values it is seen that there is a high significant difference between the spouses of patients suffering from mania and depression. Mapping is seen to be employed more by the spouses of the manics than the spouses of the depressives. This may be due to the violent disruptive nature of mania where the life of the patient and that his family is severely destabilized. Thus in terms of treatment and management the spouses will be forced to seek information regarding the illness.

From Table 4.11 it is seen that the genders show a significant difference in the employment of the coping style reversal. Table 4.12 shows that the male spouses employ this coping style more (54.07) than the female spouses (33.51). Table 4.13 shows that paranoid schizophrenia of the spouses call for the employment of the coping style reversal. Table 4.14 depicts that female and male spouse of the patients with paranoid schizophrenia employs reversal (42.36 and 57.70) respectively than the spouses of the patients with affective disorder. Reversal is the coping style where the person acts the opposite of the way he/she feels. It is only natural that a great deal of frustration and resentment is generated when there is a patient in the family suffering from paranoid schizophrenia. On to it, doubts, chaos, and confusion are added. Still the spouse has to grit his/her teeth and bear it all. Most of the time, the spouse never gets an opportunity to give vent to his/her feelings as he/she tries to maintain an outward balance. All these dynamics may explain the usage of reversal in both the genders as a means of coping. Apart from these, there is the question of social sanction if the feelings are overtly expressed. Thus reversal comes into use.

SECTION 2

HYPOTHESIS 4

Hypothesis 4 states that stress tolerance and wellbeing are related and this relationship may exhibit significant shifts where the two genders are concerned. A product moment correlation was done to examine these shifts. Table 4.20 gives the details of the computations for the entire group.

TABLE 4.20

Table showing the Correlation between the Variables – Stress tolerance, Well being and Coping Styles for the entire sample

Variables	Stress tolerance (stress score)	Well Being	Minimiza-tion (CS_1)	Suppre-ssion (CS_2)	Succo-rrance (CS_3)	Replace-ment (CS_4)	Blame (CS_5)	Substi-tution (CS_6)	Mapping (CS_7)	Reversal (CS_8)
Stress tolerance (stress score)										
Well being	-0.3723***									
Minimization (CS_1)	-0.2469	0.1413								
Suppression (CS_2)	-0.2024	0.0162	0.0861							
Succorrance (CS_3)	0.1996**	-0.1537*	0.0753	-0.0606						
Replacement (CS_4)	-0.1899*	0.1353	0.1194	0.1188	0.2608***					
Blame (CS_5)	0.0882	-0.1202	0.1015	0.2125**	0.1518*	0.1995**				
Substitution (CS_6)	0.2327	0.0214	-0.1930**	-0.0245	0.1206	0.1131	0.0300			
Mapping (CS_7)	-0.3277 ***	0.0722	0.3717***	0.1027	0.0264	0.1367	0.2128**	-0.2006**		
Reversal (CS_8)	-0.1267	0.0103	0.2439**	0.1266	-0.0086	0.1455*	0.3010***	0.0118	0.3228***	

* P<0.05, ** P<0.01, *** P<0.001

From the values, it can be seen that the variable stress tolerance bears a highly significant negative correlation to wellbeing. This means that the higher the stress, lower the sense of wellbeing. This is in tune with the theory and several of the studies done earlier. In the face of stress, wellbeing is indeed compromised.

HYPOTHESIS 5

Hypothesis 5 states that coping styles and wellbeing are related. These hypotheses were tested using correlation between pairs of variables. Coping styles selected for the present study includes four functional and four dysfunctional styles of coping namely minimization, suppression, succorance, replacement, blame, substitution, mapping and reversal. Table 4.20 presents the details of the computation for the entire group.

From the values it can be seen that the variable stress tolerance bears a highly significant negative correlation to minimization and mapping. Higher the level of stress experienced lesser the chance that minimization and mapping will come into play. As the level of stress goes up, usage of minimization – that is the tendency to minimize the importance of the problem – decreases. This may suggest that as the individual experiences the stress of having a mentally ill spouse, the situation could be so grave or urgent that minimization is never the coping style to be adopted. It doesn't help to turn a blind eye in situations like this where the situation has to be brought under control at the earliest.

The individual may not get enough of time, energy or opportunity to engage in the mapping type of coping style. He/she has to deal with the daily problems of living as well as tending to the sick spouse and taking care of the other family members dependent on them. In such a situation, emphasis is given to the quick solution of the problem at hand rather than the use of the process of mapping. Mapping may passively take place when the spouses are re-educated about the sickness of the spouse, or when they are given supportive psychotherapy.

Stress tolerance is highly positively correlated to succorance and substitution. This means that when the individual experience higher stress, he/she tend to use more substitution and succorance. Both these coping styles are positive coping styles. The correlation with succorance reveals that when the individual has a spouse who is mentally ill, it certainly calls for the help from others and in many instances he/she will actively seek it too – right from therapeutic help to help from other resources.

In substitution, the individual relieves his/her tension by engaging in tension reducing activities. When the spouse is mentally ill, the stress experienced by the husbands/wives is very high. For them to function effectively, it is important they seek avenues where their stress could be considerably reduced. For the male spouses, it could be activities like sports, while the female spouses may seek to reduce stress by tending and befriending where they verbally share their distress.

Table 4.20 reveals that stress has a significantly negative correlation at 0.05 level with suppression. This means that usage of suppression decreases as stress increases. Suppression is avoiding of the problem or the situation. Having a mentally ill spouse is the kind of situation where one can never wish away the implications of the problem. However, dysfunctional it may be, avoiding or ignoring the problem can reduce the stress experienced by not exaggerating it.

Replacement is dealing with the problem by generating alternative solutions. Replacement decreases as the stress increases. However from the Table 4.20 it can also be seen that as stress increases, help seeking increases. It is possible that replacement give way to the help seeking coping style. As the individual is not making effort to generate alternate solutions, he/she tend to depend upon others which will to an extent help him/her to handle the stress experienced.

It is also interesting to note that that wellbeing is negatively correlated to succorance. This means that individuals who enjoy a sense of wellbeing

use less of the coping style succorance. People who have spouses with mental illness and who has a sense of wellbeing in spite of their stressor need not seek the help of others. This also has an implication on the level of stress tolerance as well. As stress tolerance increases, other positive coping styles apart from help seeking come into play, so that the individual need not go around asking for help.

Table 4.20 also contains the correlational values between the coping styles as well. The high positive correlation of minimization with mapping and to reversal implies that when the importance attached to a problem is reduced, the individual can afford to act just the opposite way of how he/she really feels. Therefore, when the spouse is mentally ill and if the wife/husband employs minimization, then definitely the burden of care will come down significantly, because he/she can act in a manner where the experienced distress is portrayed otherwise.

Mapping is seen to be positively correlated to minimization. Probably mapping is used here to gather information selectively so as to justify the use of minimization. In other words mapping is used to gather only those information which justifies the use of minimization.

Substitution is seen to be highly negatively correlated with the coping style minimization. When minimization is employed, be the coping style be positive or negative, it will considerably reduce stress experienced by attaching less importance to the problem at hand, and hence there is no question of using substitution – i.e. engage in tension reducing activities, because by using minimization already the stress is managed.

Table 4.20 also shows that suppression is positively correlated in a significant way to blame. That is when suppression as avoiding the problem or situation is used it is easy for the individual to place the blame on the system, people or events and feel free of stress relatively. When blaming is employed as a coping style, the problem of having a mentally ill spouse could be put on the system, an event, or someone else, and then the

individual to a large extent is free of the responsibility at least in a psychological way.

Another feature revealed is that succorance is positively correlated to replacement and to blame. Succorance will enhance replacement and reduce blame. When there are avenues where help can be sought, it definitely will also enhance possibilities to generate solutions to deal with the problem. It can be inferred that succorance itself will cover the other three positive coping styles namely, replacement, substitution and mapping. Usage of blame could be seen as an impetus in employing help seeking. If the individual perceives another person, situation or an event as responsible for his/her spouse's mental condition, it should result in generating solutions intended to cover this perceived blame.

The correlations also show that replacement is related in a positive way to blame and reversal. The positive correlation of replacement with blame can be explained that the perception that an outside element should be blamed for the stressor would reduce the stress experienced. Once again, the employment of replacement and blame together, largely depends upon the individual's dominant styles of coping. Replacement is also positively correlated with reversal. When there are enough of alternate solutions to meet with the stressor of having a mentally ill spouse, maybe the individual can afford to turn reversal into a positive coping style. Individual, instead of acting the opposite of what he/she may be feeling about the stressor, may genuinely feel the opposite of what is expected. Thus replacement may render the burden of care to be greatly reduced. Instead of acting that the stressor is reduced the individual may really feel that the stressor is reduced.

From Table 4.20, it can also be seen that blame is positively related to mapping and reversal. Collecting information about the problem occurs in a very selective manner so that blaming is justified. The individual may seek

only that information which has no disparity with his projected blame on others or the situation.

In the case of reversal, using blame may reduce the expressed emotion. If the individual with the spouse who is mentally ill could blame the situation or an event as contributing to the current stressor, it would considerably reduce the bitterness felt towards the stressor, thus enabling the individual to act in a more forbearing manner. Hence, replacement as seen from the Table 4.20 would also be in tune with blame and reversal.

Another indication revealed in Table 4.20 is that substitution negatively correlates to mapping. Substitution is the engagement in tension reducing activities such as a physical activity (sport) or a verbal activity (ventilation). Substitution would ideally be employed after the full impact of the stressor is taken into consideration. Of all the other styles, substitution is the only coping style where actual tension relief takes place. The individual might be employing this coping style with the information at hand and hence tendency to seek further information may get reduced.

Mapping is also positively correlated to reversal. In light of the information collected about the sickness of the spouse and resentment generated by the information, the individual would have to mask the negative feelings to a great extent, because the expression of them is not socially sanctioned and act just the opposite of what he/she may feel.

It appears that a quadrangular relationship exists between replacement, blame, mapping and reversal where replacement is the initiator.

Table 4.21 depicts the results of correlational analysis done for the scores of female spouses of mentally ill to find out the relationship between stress tolerance, wellbeing, and coping styles.

TABLE 4.21

The Correlation between the Variables – Stress tolerance, Well being and Coping Styles (minimization, suppression, succorance, replacement, blame, substitution, mapping and reversal) in the female spouses of mentally ill

Variables	Stress tolerance (stress score)	Well Being	Minimiza-tion (CS_1)	Suppre-ssion (CS_2)	Succo-rrance (CS_3)	Replace-ment (CS_4)	Blame (CS_5)	Substi-tution (CS_6)	Mapping (CS_7)	Reversal (CS_8)
Stress tolerance (stress score)										
Well being	-0.1736									
Minimization (CS_1)	-0.3724	0.2745								
Suppression (CS_2)	-0.3935	-0.0088	0.3265**							
Succorrance (CS_3)	0.1153	-0.1301	-0.0333	-0.0256						
Replacement (CS_4)	-0.2060*	0.0905	0.0557	0.1609	0.3318***					
Blame (CS_5)	0.1353	-0.1277	0.0968	0.3814***	0.1306	0.0727				
Substitution (CS_6)	0.4550***	-0.1851	-0.1637	-0.1250	0.2906**	0.1926	0.3093**			
Mapping (CS_7)	-0.3385**	0.1122	0.3731***	0.2227*	0.0017	0.0558	0.2615**	-0.2127*		
Reversal (CS_8)	0.0116	0.1088	0.2505*	0.2777**	-0.0547	0.0208	0.4717***	0.2602**	0.3510***	

* P<0.05, ** P<0.01, *** P<0.001

From the Table it can be seen that stress tolerance has a highly significant negative correlation with minimization, suppression, replacement and mapping in wives whose husbands are mentally ill. Comparing the coping styles used by male spouses with sick wives and female spouses with sick husbands it can be seen that both the genders have different patterns of coping style when stress is more. It can be seen that in both men and women with higher stress scores use less of mapping as the coping style. The comparison also shows that while seeking succorance is the predominant coping style in the male spouses of mentally ill, in the female spouses of the mentally ill it is substitution.

As stress increases, usage of minimization decreases. As obvious, reducing the importance of the problem doesn't make the problem go away. Rather such minimization can be detrimental for the wife who employs it and for the whole family. Same is true for the coping style suppression. Avoiding the problem at hand can be as bad as minimizing it – especially the problem of having a husband who is mentally ill.

Replacement is not used by the female spouses of mentally ill, though one might expect them to use it. Compared to men, women are more emotionally sensitive. They react to stress easily in an emotional way than the men do. This heightened emotional arousal may adversely affect their logical thinking and reappraisal skills. Subsequently, employment of replacement would not happen. Here, however there is a high significant positive correlation of stress with substitution. This seems to suggest that probably replacement gives way to substitution. Where females are concerned it has been seen that they employ more of prosocial activities like tending and befriending to reduce their stress. So this sharing with others may result in new ideas or solutions in dealing with the problem.

Mapping is significantly correlated negatively with increasing stress in the female spouses. It is probable that they may try to solve the problem as

soon as possible, rather than putting their time and energy into collecting information about the problem immediately.

Table 4.21 shows that wellbeing is positively correlated to minimization significantly. Female spouses with mentally ill husbands may feel more comfortable when they are able to minimize the importance of the problem. Because of the array of the multiple roles females have to attend to in addition of taking care of their mentally sick husbands, it is probable that attaching too much of gravity to the problem will only undermine their own mental health. It is probable that by using minimization, the female spouses will be more able to tackle the problem in their own stride. Another explanation is that, since in our cultural scenario females are more exposed to stress and are more trained with opportunities to handle them, it would make them more or less insulated to stress. This could be one reason why females use minimization more.

Minimization has a highly significant positive correlation to mapping, suppression and reversal. Female spouses may be using mapping to selectively gather information regarding the problem of having a mentally ill husband, so that they can justifiably reduce the importance given to the problem. If the importance attached to the problem is decreased, then the female spouses can very well engage in reversal, where they can act lightly on a serious problem. Though this is a dysfunctional coping style, in this context it reduces the stress experienced by the female spouses. In the same vein, it is psychologically acceptable to engage suppression coping style in a situation whose importance is already minimized and about which the female spouses feel differently.

From Table 4.21 it can be seen that suppression has a highly significant positive correlation with blame mapping and reversal. Using of suppression results in blame which is placed on a third person, situation, or event, thus is helping the wife to be psychologically non- accountable to her husband's mental illness and subsequent problems arising from it. Mapping

could be as explained before, an attempt to collect only those information which may substantiate the use of blame and suppression. In this context, mapping and blame may also enhance the use of reversal, where the wives act the opposite of what they really feel. Another explanation is that the incidences of earlier episodes which had happened before the marriage also would increase the use of blame and thereby increase the use of mapping and reversal.

Table 4.21 speaks of a highly significant positive correlation of succorance with replacement and substitution. Help seeking no doubt will help the female spouses to generate alternate solutions just not to the problem at hand, but also to the other problems arising from the original one. In our culture where females are concerned, their only activity which may help them to take their minds off the problem may be interacting with and ventilating to other people around them like relatives or friends. This no doubt will reduce the stress and may enhance replacement.

It can be seen from the table that the coping style blame has a highly significant positive correlation with reversal, substitution, and mapping. This suggests that the blaming style of coping is probably resulting in the active searching of the information which will justify the use of blame. Once blame is directed to an outside element, wives will also feel emotionally more comfortable to handle the situation. Substitution is probably used to justify blame. Also substitution – by virtue of its ventilation effect, helps the individual to relieve any guilt they may feel because of using blame, mapping or reversal. It is noteworthy that though mapping is a positive coping style, it at times could also generate feelings of guilt. It could be negative too like a double edged sword.

It is seen from Table 4.21 that substitution has a significantly negative correlation with mapping and a significantly positive correlation with reversal. Substitution involves tension reducing physical or verbal activities. Females with their multiple roles given a chance will choose ventilation verbally as

coping technique to draw comfort from others. With most of their time spent in the physical work of running the house, there is less chance of indulging in mapping. Any mapping that will happen will be in a therapeutic context. Where the coping style reversal is concerned, substitution may help to resolve any emotional conflict, resentment or bitterness that wives may feel toward their husbands and their mental illness. Thus substitution may help the wives at least to act more tolerant with their sick spouses even though they may feel otherwise.

Mapping bears a highly significant positive correlation with reversal. Gathering information though is generally helpful, may at times dishes out unsavory facts as well. It could be particularly bad when it involves one's own husband and his mental illness. This may give rise to a host of negative feelings from the wife's part which she would have to mask or suppress because it is at variance with her role and societal expectations. Thus reversal happens.

Results of correlational analysis for the scores of the male spouses to assess the relationship among the variables, stress tolerance, wellbeing, and coping styles are shown in Table 4.22.

TABLE 4.22

The Correlation between the Variables – Stress tolerance, Well being and Coping Styles (minimization, suppression, succorance, replacement, blame, substitution, mapping and reversal) in the male spouses of mentally ill

Variables	Stress tolerance (stress score)	Well Being	Minimiza-tion (CS_1)	Suppre-ssion (CS_2)	Succo-rrance (CS_3)	Replace-ment (CS_4)	Blame (CS_5)	Substi-tution (CS_6)	Mapping (CS_7)	Reversal (CS_8)
Stress tolerance (stress score)										
Well being	-0.4433***									
Minimization (CS_1)	0.0042	-0.0709								
Suppression (CS_2)	-0.0461	0.0476	-0.1876							
Succorrance (CS_3)	0.3835***	-0.2362*	0.1242	-0.0995						
Replacement (CS_4)	0.0866	0.0030	-0.0832	0.1241	0.1258					
Blame (CS_5)	0.2646*	-0.2579*	-0.0627	0.0394	0.1086	0.0660				
Substitution (CS_6)	-0.0509	0.2831**	-0.1724	0.1105	-0.0510	0.2015	-0.2361*			
Mapping (CS_7)	-0.2261*	-0.0716	0.2815**	-0.0832	-0.0061	0.0187	0.0044	-0.1236		
Reversal (CS_8)	-0.0550	-0.2150*	0.0761	-0.0249	-0.0555	-0.0534	-0.0499	-0.1990	0.1613	

* P<0.05, ** P<0.01, *** P<0.001

From the Table 4.22 it is seen that stress is significantly negatively correlated to the coping style mapping. This implies that where the relationship between stress and mapping is concerned, the male spouses may be using other coping style or styles more than mapping. They may direct their energy to a constructive solution to the problem at hand than simply amassing information. This relationship is the same as in women spouses as observed from the Table 4.21 and the same dynamics maybe working here too.

It is also seen from the Table that stress has a high positive significant correlation with the coping styles – succorance and blame. As the levels of stress go up, men tend to seek help at one point or another. When their spouses fall sick mentally, the husband – at least most of them – has no go but to turn to their own mothers, mother-in-laws, or some other female relatives for the smooth running of the household. Here succorance is not just in getting the wife treated, but also to ensure that much of the responsibilities his wife used to carries out goes on without any serious interruption.

It is seen that husbands whose wives are mentally ill also engage in the coping style blame. Since most of the males prefer problem-focused coping style, the realization that this problem of his wife's illness will not be solved right away like a physical illness could be quite frustrating. Engaging blame may just be a fall out of this frustration. Blame may be directed to self, problems between the couple, wife's family, any family history of illness on wife's side, financial strains, environmental influences or fate.

It is interesting to note that male spouses use succorance more. There is a high level of correlation between stress and succorance than correlation result of the women spouses as shown in the Table 4.21. The reason could be that males have lot of avenues to seek help from, while for females it is limited. Also our socio cultural expectation is that females manage problems by themselves.

From Table 4.22 it can be seen that well being is negatively correlated to succorance, blame, and reversal. The only significant positive correlation is to substitution. Male spouses whose wives are mentally ill do not use help seeking all the time to deal with their stressor. The implication is that they may use more problem focused kind of coping styles in tackling the problem of treating their wives and running the house.

In the same vein, male spouses who enjoy higher levels of wellbeing need not use blame as a coping style, as there are other healthy, productive coping styles to be employed. Same is the case with reversal, because using reversal does not serve any positive outcome to the problem at hand. And the perspective of the male spouses who enjoy heightened sense of wellbeing, on the problem, tends to be less emotionally clouded, thus enhancing their reappraisal skills.

Predictably enough, male spouses with heightened sense of wellbeing use substitution more. Male spouses by the virtue of their gender, and the societal roles have more avenues to employ substitution more. They are more likely to engage in tension reducing activities as sports, involvement with friend groups, politics and simply being away from the stressful situations physically which could relieve their stress.

Table 4.22 speaks of positive correlation of the coping style minimization with mapping significantly. Here the less the amount of relevant information collected, the more the individual can engage in minimization. Being ignorant about the facts, or about the problem may significantly reduce the importance of the problem and may in turn lower the stress experienced. So the individual probably does engage in mapping, but with intent of gathering of information which will justify his use of minimization as a coping style. From Table 4.22 it can be seen that this trend is similar to that of female spouses.

It can also be seen in the Table 4.22 that blame has a significant negative correlation to substitution. The reverse of this is exhibited by the

female spouses as seen from Table 4.22. Where the male spouses are concerned, an individual employing substitution need not use blame, because his stress is already dissipated by engaging in substitution. Further more, substitution helps other coping styles to come into play which enhances the individual's general coping techniques. Thus there is little or no need for engaging blame as a coping style. Thus the four coping styles inter related in the present sample are minimization, blame, mapping and substitution.

The most interesting feature that has emerged from the correlations is that in the case of female spouses, stress is not significantly related to wellbeing. The Table 4.21 shows that the direction of the correlation is as expected but it is not correlated significantly. This is not the trend observed with the combined group and the male spouses. Probable reason for this could be the basic difference in the hardiness of men and women. Our socio cultural expectations demand females to handle any stress arising at the home front by themselves. This is true for handling their emotional crises as well. Their hardiness and stress tolerance may be slightly high due to habit formation in dealing with stress and the insulation effect.

SECTION 3

HYPOTHESES 6

Hypothesis 6 states that coping styles and stress tolerance predicts wellbeing. This hypothesis seeks to explain the predictive ability of the variables on wellbeing in both the male and female spouses of the mentally ill. For this multiple regression (stepwise) was employed. This was used not only to select the set of variables that predict wellbeing, but also to eliminate superfluous predictor variables.

Table 4.23 shows the values of multiple regressions (stepwise) on the female spouses of the mentally ill where wellbeing is taken as dependent variable.

TABLE 4.23

Results of Multiple Regression Analysis (Step wise) on FEMALE SPOUSES of mentally ill well being taken as dependent variable

Independent Variables	Multiple Regression R	F Value for R	R^2	SE for R	Regression Coefficient B	Constant	Beta Coefficient B
Minimization (CS_1)	0.2745	7.17**	0.753	3.68	0.0354	5.877	0.2745

* P<0.05, ** P<0.01, *** P<0.001

Table 4.23, consists of the result of regression done on female spouses of mentally ill, by taking wellbeing as dependent variable. It can be seen that in the female spouses, the coping style minimization only has a predictable effect on the wellbeing. The relationship of minimization to wellbeing is positive as seen from the value of partial regression coefficient (0.0354). It further indicates that wellbeing in the female spouses of mentally ill increases 0.0354 units for every unit of change in minimization. The R value (0.2745) indicates that the strength of the relationship between wellbeing and minimization is 27%. The coefficient of multiple correlation (0.753) indicates that 75% of the variance in the wellbeing of the female spouses of the mentally ill is accounted for by the variable minimization. It is seen that minimization contributes to the 75% of the wellbeing of the female spouses. Minimization is a passive way of coping where the individual minimizes the importance of the problem. For most of the females, rather than actively solving the problem of having a mentally ill spouse, minimization may suit more because they also should invest their time and energy on running the house and taking care of the others in the household who may be emotionally or otherwise dependent on them.

Table 4.24 gives the results of multiple regressions among the variables in male spouses of the mentally ill where wellbeing is the dependent variable.

TABLE 4.24

Results of Multiple Regression Analysis (Step wise) on MALE SPOUSES of mentally ill well being taken as dependent variable

Independent Variables	Multiple Regression R	F Value for R	R^2	SE for R	Regression Coefficient B	Constant	Beta Coefficient B
Stress tolerance (stress scores)	0.4430	21.52***	0.1965	4.15	-0.0459	19.56	-0.44329
Substitution (CS_6)	0.5143	15.64***	0.2545	3.99	-0.0446 (stress scores) -0.436 (CS_6)	17.54	0.2612
Reversal (CS_8)	0.5486	12.34**	0.3009	3.92	-0.459 (stress scores) -0.0371 (CS_6) -0.0316(CS_8)	19.80	-0.1951

* P<0.05, ** P<0.01, *** P<0.001

From Table 4.24 it can be seen that the first variable entered into the multiple regression analysis is stress tolerance. The R value obtained is 0.4430. The relationship is negative as indicated by the value of B, the partial regression coefficient (-0.0459). R value indicates that the strength of relationship between wellbeing and the variable stress tolerance is about 44.3%. The coefficient of multiple correlation (R^2) is 0.1965. This shows that 19% of the variance in wellbeing is accounted for by the factor stress tolerance. The partial regression coefficient (-0.0459) indicates that wellbeing decreased by 0.0459 units for every unit of change in stress tolerance.

The result suggests that higher the intensity of stress experienced or lower stress tolerance results in poor wellbeing. That is in the present sample, as the levels of stress goes up for the male spouses whose wives are mentally ill, it invariably has an impact on their sense of wellbeing.

In predicting the influence/role of coping styles on wellbeing, two sub variables have emerged significant as revealed in the Table 4.24 namely, substitution and reversal. Where substitution is concerned, the multiple correlation R is 0.514. The strength of the relationship between wellbeing and substitution with stress tolerance put together is 51.43%. The R^2 value is 0.2645 which means stress tolerance and substitution put together contributes around 26.45% of variation in wellbeing in a positive direction. That is approximately7% of increase in wellbeing is caused by substitution. The partial regression coefficient value of stress tolerance and substitution to wellbeing is positive, which means, for every unit increment in the wellbeing. The partial regression coefficient further shows that for every unit of change in stress tolerance and substitution there will be 0.0446 and 0.0436 unit changes in the value of wellbeing.

Substitution, where the emphasis is on tension reducing activities, should definitely increase or contribute to the better sense of wellbeing in male spouses whose wives are mentally ill. Substitution renders the

individual to keep his stress levels down and thus enhance his sense of wellbeing. Being males they will have enough of opportunities as compared to females to engage in tension reducing activities. Thus substitution can predict wellbeing significantly in men

The third factor that has been entered into the regression in terms of its contribution to wellbeing is reversal. The R value is found to be significant (0.548). The negative value of regression coefficient (-0.0316) indicates that wellbeing will have a decrement of 0.0316 units for every unit of change in reversal. Wellbeing will also change for every unit of change in stress tolerance and substitution respectively (0.0459 and 0.0371). The R value indicates that the strength of relationship between wellbeing and reversal is 54.86%. The R^2 (0.3009) value indicates that the total variance contributed by stress tolerance, substitution and reversal is 30%.

Reversal is acting the opposite of the way the individual feels. By engaging in reversal, the relief from stress could be only temporary. Reversal does not offer any long term solution for the problem at hand. At times it could also be detrimental as when the spouse may act cheerful outside, while he is reeling under the burden of care. He may be forced to live up to the cheerful demeanor of his facade even when he doesn't really feels so, which may add to the levels of stress. Increased stress will always result in decreased sense of wellbeing.

HYPOTHESIS 7

Hypothesis 7 states that coping styles and wellbeing predict stress tolerance in both the genders.

Table 4.25 contains the result of multiple regression analysis with stress tolerance as dependent variable for the female spouses of the mentally ill.

TABLE 4.25

Results of Multiple Regression Analysis (Step wise) on FEMALE SPOUSES of mentally ill Stress Tolerance taken as dependent variable

Independent Variables	Multiple Regression R	F Value for R	R^2	SE for R	Regression Coefficient B	Constant	Beta Coefficient B
Substitution (CS_6)	0.4549	22.97***	0.2070	34.84	0.5322	228.21	0.4549
Suppression (CS_2)	0.5657	20.67***	0.3221	32.39	0.4823 (CS_6) -0.5202 (CS_2)	257.86	-0.3419
Replacement (CS_4)	0.6159	17.51***	0.37983	31.18	0.545 (CS_6) -0.449 (CS_2) -0.3587 (CS_4)	261.31	-0.2482
Minimization (CS_1)	0.6470	15.30***	0.4187	30.35	0.5123 (CS_6) -0.3517 (CS_2) -0.3489 (CS_4) -0.2793 (CS_1)	269.47	-0.2119

* P<0.05, ** P<0.01, *** P<0.001

Table 4.25 consists of the results of multiple regression analysis done on female spouses of mentally ill, by taking stress tolerance as dependent variable. It is seen that substitution predicts stress tolerance in a positive direction from the value of regression coefficient (0.5322). It also suggests that stress tolerance increases by 0.5322 units for every unit of increase in substitution. The highly significant R value (0.4549) indicates that the strength of relationship between substitution and stress tolerance to be 45.49%. R^2 (0.2070) indicates that 20.70 % of variance in stress tolerance is accounted for by substitution.

Substitution is the engagement in tension reducing activities – especially recreational in nature. It is plain knowledge that activities such as TV viewing, reading, ventilating and engaging in an optimally strenuous physical or intellectual activities serve to reduce stress. For the wives with mentally ill spouses, some of these activities in the confines of their homes might serve to reduce their stress.

Next variable to enter into the table is suppression. From the table it can be seen that the R value is (0.5657). The strength of the relation between stress tolerance and, substitution and suppression is 56.57%. The R^2 value is found to be 0.3221. This means that the substitution and suppression put together contributes around 32.21 % of variation in stress tolerance in a negative direction. The regression coefficient value indicates that the contribution of each of the independent variables to stress tolerance will change by 0.482 and -0.520 units respectively, thus changing the stress tolerance.

Suppression is the avoidance of the problem or the situation. In the context of Indian culture, it is never easy for the female spouse to avoid the problem of having a mentally ill spouse, though sometimes her male counterpart can pull it off. If she engages in suppression, it will not only prevent her from solving the problem at hand, but aggravate the problem

and increase her levels of experienced stress. Adoption of such a coping style will affect the whole family.

The third factor that predicts the stress tolerance in the female spouses of mentally ill is replacement. The R value is 0.615. The addition of replacement is found to have increased the strength of relationship of substitution, suppression and replacement to stress tolerance by 61%. The R^2 (0.3793) indicates that the total variance contributed by these variables to stress tolerance is 37%. The partial regression coefficient value B indicates that the contribution of each of these independent variables to stress tolerance changes stress tolerance by 0.545, -0.449 and -0.3587 units respectively.

Replacement is supposed to be a positive coping style and hence the more the person uses it the more stress tolerant or less the stress experienced, which is justified by the negative B.

The fourth important factor that predicts stress tolerance is the coping style minimization with a R value of 0.6470. The R^2 value (0.4184) suggests that the four independent variables put together will contribute for 41.84% variation in the stress tolerance. According to partial regression coefficient B, for every unit of change in substitution, suppression, replacement, and minimization, there will be a change of 0.512, -0.357,-0.348, and -0.279 units in stress tolerance of the female spouses of mentally ill. It can also be seen that the change is in negative direction. For every unit of increase in minimization there is decrement in stress tolerance by- 0.279 units. The more the usage of minimization, higher the stress experienced.

Table 4.26 consists of the multiple regressions done on the male spouses.

TABLE 4.26

Results of Multiple Regression Analysis (Step wise) on MALE SPOUSES of mentally ill Stress Tolerance taken as dependent variable

Independent Variables	Multiple Regression R	F Value for R	R^2	SE for R	Regression Coefficient B	Constant	Beta Coefficient B
Well being	0.4430	21.52***	0.1965	40.09	-4.277	264.69	-0.4432
Help seeking	0.5280	16.81***	0.2788	38.20	-3.605 (Well being) -0.54310 (CS_3)	219.40	0.2952
Mapping (CS_7)	0.5849	14.91***	0.3421	36.70	-3.7933 (Well being) 0.5310 (CS_3) -0.5042 (CS_7)	255.14	-0.2524

* P<0.05, ** P<0.01, *** P<0.001

Where the male spouses are concerned the first variable that is entered into the analysis is wellbeing. The R value is found to be 0.4430, which indicates that the strength of relationship between stress tolerance and wellbeing is about 44.3%. The R^2 value of 0.1965 indicates that 19% of the variance in stress tolerance is accounted for by the factor wellbeing. Partial regression coefficient B is 0.4432 which indicates that the relationship is negative, and stress will change 0.4432 units for every unit of change in the wellbeing in a negative direction.

It can be deduced from the table that the sense of wellbeing decreases as stress increases. The male spouses with mentally ill wives experience less wellbeing because of the stress experienced.

It can be further seen from the table that succorance has a positive predictive relationship with stress tolerance as seen from the partial regression coefficient value (0.5422). Stress changes with 0.5422 units of change in succorance and 3.605 units of changes in wellbeing respectively. Multiple regression R is found to be 0.5280. This indicates that succorance and wellbeing contributes to 52.80% of stress together. The R^2 value (0.2645) means that succorance and wellbeing taken together will contribute to 26.45% of variation in stress tolerance of the male spouses of mentally ill.

Succorance opens up avenues for support in a material as well as emotional way apart from the immediate solution to the problem such as a professional help in the case of having a mentally ill spouse. Receiving help definitely increases wellbeing and decreases stress because there are some options open towards the solution, or at least, managing of the problem.

The third contributing factor entered into the table is the coping style mapping. The value of R is 0.5849. The addition of mapping is seen to increase the relationship between wellbeing and succorance to stress tolerance to 58.49%. The R^2 (0.3421) value indicates that the total variance contributed by wellbeing and succorance is 34.21%. The partial regression coefficient value B indicates the contribution of each of these independent

variables to the stress. For each unit of change in the wellbeing, succorance, and mapping, there will be -3.79, 0.53 and -0.504 units change in the stress tolerance. It can be seen that mapping negatively predicts stress tolerance.

Mapping which is the gathering of information, though is expected to reduce the stress, sometimes it could increase the stress as well, especially in this sample. For example the knowledge that the prognosis of the paranoid schizophrenia is not very good, or the knowledge that patients with recurrent mood disorders need to be on longer periods of prophylactic treatment can increase the stress. In such cases the more one indulges in mapping, more the stress experienced.

Besides testing the hypotheses formulated in the study with respect to the stress tolerance, wellbeing, and coping styles verifying the gender differences, a post hoc analysis of the results to inquire into the role of socio demographic factors were also attempted. The socio demographic variables tested were age, socio economic status and employment status, nature of the family, chronicity of the illness and duration of the marriage. ANOVA and 't' tests were the statistical techniques chosen to estimate the differences.

Results of the Table 4.27 reveal that employment of the spouses has a definite impact on the variable wellbeing.

TABLE 4.27

't' test of Variable Employment on Stress, Wellbeing and Coping Styles of Spouses of Manics

Variables	Females (N=18)		Males (N=42)		Total
	Means	SDs	Mean	SDs	
Stress tolerance (Stress score)	236.77	33.84	217.23	31.47	-2.15
Well being	6.77	4.36	9.97	4.57	2.51*
CS1 - Minimisation	53.38	26.12	45.14	26.37	-1.11
CS2 - Suppression	56.61	22.46	50.73	22.97	-0.91
CS3 - Succorance	67.66	26.23	64.85	22.49	-0.42
CS4 - Replacement	29.05	30.94	53.45	29.02	2-93**
CS5 - Blame	38.55	23.22	56.83	27.08	2.49
CS6 - Substitution	30.50	21.64	46.85	26.53	2.30
CS7 - Mapping	68.44	25.67	65.40	22.09	-0.47
CS8 - Reversal	27.38	28.81	44.38	27.45	2.16

* P<0.05, ** P<0.01, *** P<0.001

It is seen from the Table that employment of the spouses have a definite impact on the variable wellbeing and on the coping style replacement. The acute onset and the destabilizing nature of the mania may prompt quicker actions from the employed spouses. Maybe the female spouse has a higher level of burden of care than the male spouses, and hence they may enjoy comparatively lesser sense of wellbeing than their male counterparts. This could also explain their comparatively lesser usage of the coping style replacement, where generation of alternate solutions takes place than their male counterparts. It could be safely thus deduced that the burden of care of the female spouses, and their somewhat different coping styles account for this difference where the variable employment is concerened.

From the results of Table 4.28, it is seen that employment of the spouses of the paranoid schizophrenics has an impact on the main variables chose in the study.

TABLE 4.28

't' test of Variable Employment on Stress, Wellbeing and Coping Styles of Spouses of Schizophrenics

Variables	Females (N=18)		Males (N=42)		Total
	Means	SDs	Mean	SDs	
Stress tolerance (Stress score)	294.22	26.40	270.51	30.33	-3.04**
Well being	5.16	1.91	6.09	2.59	1.54
CS1 - Minimisation	22.38	17.76	59.14	27.93	6.12***
CS2 - Suppression	37.44	19.99	50.45	27.01	2.07*
CS3 - Succorance	70.05	19.62	83.90	14.89	2.68*
CS4 - Replacement	23.83	14.75	53.02	26.59	5.43***
CS5 - Blame	48.96	27.72	65.85	26.68	2.29*
CS6 - Substitution	82.22	17.40	45.52	28.81	-6.67***
CS7 - Mapping	25.61	24.46	58.21	28.03	4.52***
CS8 - Reversal	34.11	26.68	56.85	29.93	2.91**

* P<0.05, ** P<0.01, *** P<0.001

Table 4.28 shows that the female spouses who are employed undergo more stress and subsequently experiences lesser sense of wellbeing than their male counterparts. Though employment may open avenues for more socialization and better access to resources, the female spouses may find the multiple roles difficult to manage. This may explain the lowered wellbeing. It is found that the female spouses use minimization less compared to the male spouses. The employment of substitution, that is engaging in tension reduction activities by ventilating and befriending, will be more because for the females who are employed, there are more opportunities to do so. Also women disclose their distress better than the males. It is seen that the women do not engage in coping styles blame, mapping and reversal as men does. Help seeking and suppression are more employed by men than their female counterparts. Maybe, because women feel more responsible for their families, they try harder to keep the family together, rather than reducing their psychological discomfort. The increased stress, poor wellbeing and the engagement of the coping style replacement more could also be unique to the illness of their spouses, namely paranoid

schizophrenia, where the burden of care is more and where the wives may have difficulty to meet the demands of the multiple roles.

Table 4.29 shows the results of 't' test done on the spouses of the depressives to determine the differences on the main variables by the socio demographic variable employment.

TABLE 4.29

't' test of Variable Employment on Stress, Wellbeing and Coping Styles of Spouses of Depressives

Variables	Females (N=20)		Males (N=40)		Total
	Means	SDs	Mean	SDs	
Stress tolerance (Stress score)	242.25	39.53	203.85	31.97	-3.77**
Well being	8.25	3.56	11.02	4.32	2.64
CS1 - Minimisation	56.60	32.29	59.62	32.01	0.35
CS2 - Suppression	64.65	24.58	53.87	20.22	-1.69
CS3 - Succorance	60.10	29.76	61.95	28.32	0.23
CS4 - Replacement	28.25	30.43	42.62	34.57	1.65
CS5 - Blame	30.30	24.53	39.12	28.73	1.24
CS6 - Substitution	30.85	29.03	29.55	29.93	-0.16
CS7 - Mapping	59.15	29.94	66.77	27.98	0.95
CS8 - Reversal	29.25	30.41	48.47	31.71	2.28

* P<0.05, ** P<0.01, *** P<0.001

From the Table 4.29 it is found that the employed female spouses of the depressives experience more stress and subsequently lowered sense of wellbeing than their male counterparts. Here also as seen in the female spouses of manics and paranoid schizophrenics, the wives of the depressives may have difficulties with the multiple roles. Moreover, where the Indian cultural scenario is concerened, females are accountable for all their actions and the subsequent fall out of them. This may render them extra vigilant in the case of the coping styles they employ thus increasing their perceived levels of stress and decreasing their sense of wellbeing.

From the ANOVA Table 4.30, it is seen that there is a difference between the genders on all the main variables i.e. stress tolerance,

wellbeing and coping styles, where the socio demographic variable chronicity of the illness is concerned in the spouses of the manics.

TABLE 4.30

One Way ANOVA between spouses of manics on Stress tolerance, Wellbeing and Coping Styles by the variable Chronicity

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance (Stress score)	BG	2	128.67	64.33	0.05
	WG	57	64778.72	1136.46	
	Total	59	64907.40		
Well being	BG	2	183.02	91.51	4.62*
	WG	57	1127.95	19.78	
	Total	59	1310.98		
CS1 - Minimisation	BG	2	1700.98	850.49	1.23
	WG	57	39273.20	689.00	
	Total	59	40974.18		
CS2 - Suppression	BG	2	450.14	225.07	0.21
	WG	57	30198.85	529.80	
	Total	59	30649.00		
CS3 - Succorance	BG	2	232.59	116.29	0.20
	WG	57	32404.00	568.49	
	Total	59	32636.60		
CS4 - Replacement	BG	2	1004.90	502.45	0.49
	WG	57	57316.02	1005.54	
	Total	59	58320.93		
CS5 - Blame	BG	2	1139.67	569.83	0.76
	WG	57	42307.97	742,24	
	Total	59	43447.65		
CS6 - Substitution	BG	2	185.79	92.89	0.13
	WG	57	40013.05	701.98	
	Total	59	40198.85		
CS7 - Mapping	BG	2	1381.68	690.84	1.31
	WG	57	29949.29	525.42	
	Total	59	31330.98		
CS8 - Reversal	BG	2	411.51	205.75	0.24
	WG	57	48256.67	846.60	
	Total	59	48668.18		

BG - Between groups, WG - Within groups
* P<0.05, ** P<0.01, *** P<0.001

To determine the exact nature of the difference, a post hoc Scheffe's test was done and the results are shown in Table 4.30.1

TABLE 4.30.1

Scheffe's F value for the variable Wellbeing on the spouses of Manics by the Variable Chronicity

Group	Means	F
6 months - 1 year	1.016	4.625*
1 year - 5 years	3.123	
5 years - 10 years	4.14	

* P<0.05, ** P<0.01, *** P<0.001

It is very evident from the Table that longer the duration of the illness, the more it undermines the sense of wellbeing. It could be safely assumed that the exposure to the prolonged stress can have a telling effect on the stress tolerance and wellbeing of the spouses.

Table 4.31 shows that there is a significant difference on the coping styles by the variable duration of marriage in the spouses of the manics.

TABLE 4.31

One way ANOVA on the spouses of Manics on Stress tolerance, Wellbeing and Coping styles by the variable Duration of Marriage

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance (Stress score)	BG	2	2655.54	1327.77	1.21
	WG	57	62257.85	1092.13	
	Total	59	64907.40		
Well being	BG	2	117.47	58.73	2.80
	WG	57	1193.51	20.93	
	Total	59	1310.98		
CS1 - Minimisation	BG	2	195.47	97.73	0.13
	WG	57	40778.70	715.41	
	Total	59	40974.18		
CS2 - Suppression	BG	2	497.46	248.73	0.47
	WG	57	30151.53	528.97	
	Total	59	30649.00		
CS3 - Succorance	BG	2	903.08	451.54	0.81
	WG	57	31733.51	556.72	
	Total	59	32636.60		
CS4 - Replacement	BG	2	9101.73	4550.86	5.27**
	WG	57	49219.19	863.49	
	Total	59	58320.93		
CS5 - Blame	BG	2	4008.83	2004.41	2.89
	WG	57	39438.81	691.90	
	Total	59	43447.65		
CS6 - Substitution	BG	2	2123.15	1061.57	1.58
	WG	57	38075.69	667.99	
	Total	59	40198.85		
CS7 - Mapping	BG	2	312.89	156.44	0.28
	WG	57	31018.09	544.17	
	Total	59	31330.98		
CS8 - Reversal	BG	2	5519.52	2759.76	3.64*
	WG	57	43148.65	756.99	
	Total	59	48668.18		

BG - Between groups, WG - Within groups
* P<0.05, ** P<0.01, *** P<0.001

The difference is correctly estimated by the Scheffe's test, the results of which is depicted in Table 4.31.1

TABLE 4.31.1

Scheffe's F value for the variable Coping style replacement on the spouses of Manics by the Variable Duration of Marriage

Group	Means	F
6 months - 1 year	4.83	5.27**
1 year - 5 years	27.16	
5 years - 10 years	22.32	

* P<0.05, ** P<0.01, *** P<0.001

It is seen that replacement is used most by those spouses whose marriage is older than a year and younger than five years. It is seen that these spouses are keener in generating the alternate solutions for their spouses' illness. Longer the marriage, more do the spouses get to know about their husbands'/wives' problems, that they stop fighting the problem and get resigned to the fact.

From the Scheffe's Table 4.31.2, it is seen that those spouses who are in the early months of their marriage employs reversal more.

TABLE 4.31.2

Scheffe's F value for the variable Coping style reversal on the spouses of Manics by the Variable Duration of Marriage

Group	Means	F
6 months - 1 year	23.28	3.64*
1 year - 5 years	16.38	
5 years - 10 years	23.26	

* P<0.05, ** P<0.01, *** P<0.001

In the couples who are married for five years or more, the knowledge of the exact nature of the illness and awareness as many attributes of the patient himself/herself which may act against quick remission and the maintenance of a euthymic state may result in lot of resentment and bitterness. Reversal may be used by the spouses to cover up these emotions and sentiments.

The newly married couple will be under great pressure from the family to continue with the marriage despite the mental illness of the spouse. This is particularly true in the Indian scenario. So then the spouse of the mentally ill is compelled to use the coping style reversal where he/she has to mask his/her true feelings.

So far, only those results that have indicated any significant difference are discussed. Results for the other socio demographic variables which do not show any significant differences are attached as appendices.

SUMMARY AND CONCLUSIONS

Sandhya. C. “Stress tolerance, coping styles and well-being of women spouses of mentally ill” Thesis. Department of Psychology , University of Calicut, 2008

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Chapter 5

Summary and Conclusion

- *Objectives*
- *Hypotheses*
- *Sample*
- *Tools*
- *Statistical Analysis*
- *Major Findings*
- *Conclusions*
- *Scope of the Study*
- *Limitations and Suggestions for future research*

As never before, women, their problems and challenges have come to the fore. Many of the issues faced by women have found for themselves a platform where they could be addressed and discussed. Specifically, women's physical and mental health is influenced substantially by physiological and social role changes during the life stages. Viewed from this life course perspective, gender influences life experiences, psychological development, and functioning and the nature of the psychopathology (Hammen, 2003), and so can result in different psychological developmental patterns. Gender refers to women's and men's roles and responsibilities that are socially determined. Gender is related to how we are perceived and expected to think and act as women, and men because of the way society is organized, not because of the biological difference (Thara and Patel, 2001).

Family life is the key unit in the society through which basic needs are met. Research by Campbell, Heady and Wearing, and Veenhoven consistently suggests that subjective wellbeing is strongly affected by the quality of the marital relationships and family life as pointed out by Weston (1999). A strong positive relationship not only implies that those happy with family life tend to be happy with life in general, but also that pervasive discontent is likely to coexist with unhappy marriage or family life.

When a spouse is mentally ill, instead of disintegrating the ideal thing to happen in a family is reorganization. This is more apt for a pluralistic society as in India. However mental illness involves lot of chaos and conflict. Perceived controllability is considered to be an important dimension when it

comes to categorizing the characteristics of stressful life events (Lamana and Reidman, 2003). Mental illness of the spouse is one life event where there is total loss of perceived controllability over a period of time.

Mental health, mental health problems and mental disorders result from the complex combinations of biological, psychological, social and structural interactions. Opportunities for people to exercise control over their lives and set goals, to use their skills, to have a range of experiences, and to engage in supportive social interactions are important to mental health (WHO, 1998). All these are defeated to a larger extent when a spouse is mentally sick. It is in this context that the stress faced by the carer comes to the fore. Living in an environment of chronic stress, trauma, loss grief and fatigue can also lead spouses to their own parallel disorders. Parallel disorders of family members are also known as secondary or vicarious traumatization which is presented as denial, minimization, high tolerance of inappropriate behavior, confusion and doubt, guilt and depression, and other physical and emotional problems.

It is in this background that the present study seeks to find out the coping styles employed by the spouses of the mentally ill so as to enhance their subjective wellbeing and to improve their stress tolerance so that the carer role and the burden it presents become bearable with emphasis on the women spouse.

OBJECTIVES OF THE STUDY

The study is designed with four objectives:

1. To study the stress tolerance of the women spouse of the mentally ill.
2. To study the coping styles of the women spouses of the mentally ill.
3. To study the wellbeing of the women spouses of the mentally ill.
4. To study the relationship between stress tolerance, coping styles and wellbeing of the women spouses of the mentally ill.

HYPOTHESES

A few hypotheses are framed to be tested in this study.

1. Women whose husbands are mentally ill differ from husbands whose wives are mentally ill in terms of stress tolerance.

2. Women whose husbands are mentally ill differ from husbands whose wives are mentally ill in terms of coping styles.

3. Women whose husbands are mentally ill differ from husbands whose wives are mentally ill in terms of well being.

4. Stress tolerance and well being are related in the spouses of mentally ill.

   a). Stress tolerance and wellbeing are related in the female spouses.

   b). Stress tolerance and wellbeing are related in the male spouses.

5. Coping styles and well being are related in the spouses of mentally ill.

   a) Coping styles and wellbeing are related in the female spouses.

   b) Coping styles and wellbeing are related in the male spouses.

6. Coping styles and stress tolerance predict wellbeing in both the genders whose spouses are mentally ill.

   a) Different coping styles and stress tolerance can be used to predict the wellbeing in the female spouses.

   b) Different coping styles and stress tolerance can be used to predict the wellbeing in the male spouses.

7. Coping styles and wellbeing predict stress tolerance in both the genders whose spouses are mentally ill.

   a). Different coping styles and wellbeing can be used to predict the

stress tolerance in the female spouses of the mentally ill.

b). Different coping styles and wellbeing can be used to predict the stress tolerance in the male spouses of the mentally ill.

SAMPLE

The sample of the study consisted of two categories of population, namely wives with husbands who suffer from mental illness and husbands whose wives suffer from mental illness. The total strength of the sample was 180. The group consisted of 90 male spouses with mentally sick wives and 90 female spouses with sick husbands. The sampling method used was purposive sampling and the sample was a non random one. The spouses suffered from mania, schizophrenia – paranoid type, and depression.

TOOLS

Tools used in this study included three standardized self report measures and an information schedule.

1. To study the stress tolerance of the sample a Malayalam adaptation of Life Change Events Inventory by Paul and Moorthy in 1992 was used. The scale consists of 67 items related to day to day life events. The subjects were asked to mark their rating to each incident, when it occurred or if it occurred in their lives.

2. A Malayalam adaptation of PGI General Wellbeing measure by Serena and Anita in 2004 was used to study the wellbeing. The scale consists of 20 items and the respondents were asked to tick the statements which are applicable to them.

3. Coping style was studied using the Malayalam adaptation (Shanty and Anita, 2006) of AECOM Coping Scale. The scale consists of 87 items each rated by the subject on a 4 point scale ranging from 'never to often'

4. An information schedule was prepared to collect the general demographic details and some relevant information regarding the disability.

ADMINISTRATION

All the four measures were administered individually to all the subjects in the sample.

STATISTICAL ANALYSIS OF DATA

After scoring the responses of each test, as per the directions of the authors, the scores were tabulated and was analyzed statistically. The first three hypotheses were tested using two-way ANOVA and Scheffe's test where ever necessary. Fourth and fifth hypotheses were tested using Product Moment Correlation. Stepwise multiple regression were used to verify the sixth and seventh hypotheses.

MAJOR FINDINGS

Major findings of the present investigation are as follows:

1. Men and women whose spouses are mentally ill differ significantly in terms of *stress tolerance.*

2. Female spouses whose husbands suffer from paranoid schizophrenia experiences more stress than female and male spouses whose spouses suffer from affective disorders.

3. In both the genders *wellbeing* is significantly correlated with the stress experienced. Thus both the genders whose spouses have paranoid schizophrenia experiences poorer sense of *wellbeing.*

4. The coping style *succorance* is employed extensively by both the genders whose spouses suffer from paranoid schizophrenia.

5. The coping styles *blame* and *substitution* are the most used coping styles by the female spouses whose husbands suffer from paranoid schizophrenia.

6. The coping styles *substitution, blame, mapping*, and *reversal* are positively correlated with each other to the extent of forming a quadrangular relationship.

7. In the male spouses with wives who are mentally ill, the most used coping style is *succorance,* while in the female spouses it is *substitution.*

8. Stress tolerance predicts wellbeing in both the genders.

9. Coping style *substitution* predicts wellbeing in male spouses whose wives are mentally ill.

10. Coping style *minimization* predicts wellbeing in the female spouse of mentally ill.

11. Coping style *substitution* predicts stress tolerance in the female spouses of the mentally ill.

12. Coping style *succorance* predicts stress tolerance in the male spouses whose husbands are mentally ill.

CONLUSIONS

1. The first hypothesis framed in the study stands accepted indicating that women whose husbands are mentally ill differ from men whose wives are mentally ill in terms of stress tolerance.

2. The second hypothesis stands accepted indicating that women whose husbands are mentally ill differ from men whose wives are mentally ill in terms of wellbeing.

3. The third hypothesis stating that the coping styles of female spouses with mentally ill husbands will differ from the coping styles of the male spouses whose husbands are mentally ill stands accepted.

4. The fourth hypothesis which states that stress tolerance and wellbeing are related in the spouses of the mentally ill is split into two sub- hypotheses. The sub-hypothesis 4-a which states that stress tolerance and wellbeing is related in the female spouses of the mentally ill is rejected, and the sub-hypothesis 4-b which states that stress tolerance and wellbeing is related in the male spouses of the mentally ill is accepted.

5. The fifth hypothesis stands accepted indicating that coping styles and wellbeing are related in the spouses of the mentally ill. This is true for both the female and male spouses of the mentally ill.

6. The sixth hypothesis which states that coping styles and stress tolerance predict wellbeing in the spouses of the mentally ill is split into sub- hypotheses 6-a and 6-b. Hypothesis 6-a which states that different coping styles and stress tolerance could be used to predict wellbeing in the female spouses of the mentally ill stands rejected, and hypothesis 6-b which states that different coping styles and stress tolerance could be used to predict wellbeing in the male spouses of the mentally ill stands accepted.

7. The seventh hypothesis which states that coping styles and wellbeing predict stress tolerance in the spouses of the mentally ill is spilt into sub- hypotheses 7-a and 7-b. Hypothesis 7-a which states that different coping styles and wellbeing could be used to predict stress tolerance in the female spouses of the mentally ill stands rejected, and hypothesis 7-b which states that different coping styles and wellbeing could be used to predict stress tolerance in the male spouses of the mentally ill stands accepted.

SCOPE OF THE STUDY

Contribution of a healthy woman directly to the family and thus indirectly to the society is quite immense and positive. In this context, it is relevant that the emotional status, coping abilities, and capacity to handle stress be studied, so that the results of the study could be implemented toward helping those women who lack in the above mentioned variables. Most of the time, all the attention is given to the mentally sick spouse. The wife/husband is just considered as a bystander who imparts the relevant information. In the Indian scenario the concern about the burden of care is in its infancy and its implication towards the parallel disorders of the spouse who is the caregiver, and towards the prognostic possibilities where the sick spouse is concerned is largely ignored. The study is aimed to be an eye opener towards the issues faced by the women who are the caregivers of their sick husbands. It is aimed at the emergence of the newer ideas of research where substantial contribution could be made to ease the burden of care suffered by the female spouses by enhancing their coping styles and thus improving their stress tolerance and subsequently their sense of wellbeing. It is also true that the existence of the above mentioned variables in a positive direction in the family of the mentally ill will help to maintain the improved prognostic status of the patient. Also improved stress tolerance and wellbeing of the wife goes along way towards binding the family together in the face of a major crisis like the mental illness of the husband. The feeling of well being experienced by the mother is also extended towards her children and this extension has its final effect on the community at large. The ultimate direct result is the new closeness and warmth and improved mental health experienced by the family of the mentally ill, and the indirect result is the positive attitude in dealing with mental illness which is extended to and reflected in the community.

LIMITATIONS AND SUGGESTIONS FOR FUTURE RESEARCH

- The entire sample was taken from a single hospital. Influence of a more spread out socio demographical factors could not come into play in such a sample as this.
- By giving more thrust to the socio demographical influences, aspects which are ignored, or are not apparently obvious could be identified
- The improvement made by the patients and their spouses by the virtue of the employment of the coping styles could be studied.
- In future researches, if the burden of care experienced by the spouses in each disorder and the coping styles used to be studied, more practical implications could emerge.
- And finally, the study would have been more meaningful if an attempt to understand the implications of the stress management and the employment of coping styles in a therapeutic situation were also considered.

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Appendices

APPENDIX - A

INFORMATION SCHEDULE

1. Name :

2. Age :

3. Religion :

4. Educational Status :

5. Employment status :

6. Employment status of the Spouse :

7. Socio-Economic Status : Lower Class / Middle Class / Upper Class

   a) Availability of food in the family — Adequate/Inadequate/In plenty

   b) Availability of luxurious electrical appliances at home — Yes/No

   c) Availability of adequate space and Privacy at home — Yes/No

8. Duration of marriage
   6months – 1 year/1year – 5 years/ 5 years – 10 years

9. Illness of spouse is diagnosed as — Mania/Schizophrenia Paranoid Type/ Depression

10. Chronicity of the illness : 6months-1year/1year-5years/5years-10years

APPENDIX - B

DEPARTMENT OF PSYCHOLOGY
Calicut University

Life-Change Events Inventory

നിർദ്ദേശങ്ങൾ

ദൈനംദിന ജീവിതവുമായി ബന്ധപ്പെട്ട ഏതാനും പ്രസ്താവനകൾ താഴെ കൊടുത്തിരിക്കുന്നു. കഴിഞ്ഞ ഒരു വർഷത്തെ നിങ്ങളുടെ അനുഭവം വെച്ച് നോക്കുമ്പോൾ സ്വീകാര്യമായി തോന്നുന്ന പ്രസ്താവന കളുടെ ക്രമനമ്പറിൽ ശരി അടയാണം രേഖപ്പെടുത്തുക. നിങ്ങൾക്ക് ഇല്ലാത്ത അനുഭവമായാൽ കൂടിയും അവ ഉണ്ടായാൽ ഉള്ള പ്രത്യാഘാതം രേഖപ്പെടുത്തുക. ഓരോ സംഭവവും നിങ്ങളിൽ ഉണ്ടാക്കിയേക്കാവുന്ന പ്രത്യാഘാതം 1 മുതൽ 5 വരെയുള്ള തോതിൽ അടയാളപ്പെടുത്തുക.

1 - വളരെ കുറവ്
2 - വളരെ കൂടുതൽ

1.	ഭാര്യയുടേയോ/ഭർത്താവിന്റെയോ മരണം	1
2.	താനോ അടുത്ത ബന്ധുവോ ജയിൽ ശിക്ഷക്കു വിധേയമായത്	2
3.	വളരെ അടുത്ത ബന്ധുവിന്റെ മരണം	3
4.	കുടുംബത്തിൽ ഒരാളുടെ ഗൗരവമേറിയ മാനസികരോഗം	4
5.	ഉദ്യോഗത്തിൽനിന്ന് താൽക്കാലികമായോ സ്ഥിരമായോ പിരിച്ചുവിട്ടത്	5
6.	വേർപെട്ടു താമസിക്കൽ / വിവാഹമോചനം	6
7.	വ്യവസായത്തിലെ പരാജയം	7
8.	മകനോ, മകളോ വീട് വിട്ടുപോയത്	8
9.	ഗൗരവമേറിയ രോഗമോ, മുറിവോ മൂലം ആസ്പത്രിയിൽ കഴിയേണ്ടിവന്നത് അഥവാ ഒരു മാസത്തേക്ക് ഉദ്യോഗത്തിൽനിന്ന് വിട്ടു നിൽക്കേണ്ടിവന്നത്	9
10.	കുടുംബത്തിൽ ഒരാളുടെ ഗുരുതരമായ രോഗം	10
11.	സന്താനങ്ങൾ ഇല്ലായ്മ	11
12.	ദാമ്പത്യ സംഘർഷങ്ങൾ	12
13.	ഭാരിച്ച കടബാധ്യതയിൽപ്പെട്ടത്	13
14.	സുഹൃത്തിന്റെ മരണം	14
15.	ദാമ്പത്യപ്രശ്നങ്ങളല്ലാത്ത കാരണങ്ങളാൽ ഭാര്യയിൽ നിന്ന്/ഭർത്താവിൽ നിന്ന് വേർപെട്ടുജീവിക്കേണ്ടി വന്നത്.	15
16.	പരീക്ഷയിലെ തോൽവി	16
17.	ഭാര്യയുടെ/ഭർത്താവിന്റെ ദാമ്പത്യേതര ബന്ധങ്ങൾ	17
18.	ഉദ്യോഗം നിഷേധിക്കപ്പെട്ടത്.	18
19.	കുടുംബാംഗം വീട് വിട്ട് പോയത്	19
20.	വസ്തുവകകൾ/വിളവ് നശിച്ചത്.	20
21.	പോലീസ്/സർക്കാർ അധികൃതരുമായുള്ള ഗൗരവമായ പ്രശ്നം	21
22.	നിങ്ങളുടെ/കുടുംബത്തിലൊരാളുടെ തൊഴിലില്ലായ്മ	22

59.	ആശിച്ച ഗർഭധാരണം	59
60.	വിവാഹം നിശ്ചയിച്ചത്	60
61.	ജോത്സ്യപ്രവചനം	61
62.	സാമൂഹിക പ്രവർത്തനങ്ങളിലെ മാറ്റം	62
63.	കുടുംബപരമായ ചടങ്ങുകളുടെ കുറവ്	63
64.	വ്യക്തിപരമായി വൻനേട്ടം കൈവരിച്ചത്	64
65.	അവധിയിലോ, തീർത്ഥാടനത്തിനോ പോയത്	65
66.	ഉറക്കശീലത്തിൽ ഉണ്ടായ മാറ്റം.	66
67.	ഭക്ഷണരീതിയിൽ വന്ന മാറ്റം	67

AGE:

SEX:

EDUCATIONAL:

QUALIFICATION:

CODE NO.:

RELIGION:

MARITAL STATUS: M/UM

OCCUPATION: WORKING

NON-WORKING

STUDENT

DOMICILE: URBAN/RURAL/SUB URBAN

APPENDIX - C

PGI General Well Being Measure

S.K. Verma & Anita Verma

പേര് :

വയസ്സ് :

സ്ത്രീ/പുരുഷൻ :

വിലാസം :

നിർദ്ദേശം:- ദൈനംദിന ജീവിതത്തെ വിലയിരുത്താനുതകുന്ന ഏതാനും പ്രസ്താവനകൾ താഴെ കൊടുത്തിരിക്കുന്നു. കഴിഞ്ഞ ഒരു മാസത്തെ നിങ്ങളുടെ വെളിച്ചത്തിൽ സ്വീകാര്യ മായിത്തോന്നുന്ന പ്രസ്താവനകൾക്കു നേരെ ( ) അടയാളം രേഖപ്പെടുത്തുക. നിങ്ങ ളുടെ അഭിപ്രായങ്ങൾ ഗവേഷണത്തിന് മാത്രമേ ഉപയോഗിക്കുകയുള്ളൂ.

1. ഓജസ്സോടുകൂടിയതായിരുന്നു.
2. വികാരങ്ങളും പെരുമാറ്റവും പരിപൂർണ്ണനിയന്ത്രണത്തിൽ ആയിരുന്നു.
3. സ്വകാര്യ ജീവിതത്തിൽ തീർത്തും സംതൃപ്തിയുണ്ട്.
4. ജീവിതത്തോട് ഏറെ പ്രതിപത്തിയുണ്ട്.
5. സുഖമായി ഉറങ്ങാറുണ്ട്.
6. പലപ്പോഴും വൈകാരികമായ പക്വതയും സ്ഥിരതയുമുണ്ട്.
7. മിക്കപ്പോഴും മാനസികസംഘർഷമില്ലാത്ത അനനഭവപ്പെടുന്നു.
8. മിക്കപ്പോഴും ഊർജ്ജസ്വലനാണെന്ന് അനുഭവപ്പെടുന്നു.
9. മിക്കപ്പോഴും ഉത്സാഹവും സന്തോഷവും തോന്നുന്നു
10. പിരഭ്രമമോ സങ്കോചമോ അലട്ടാറില്ല.
11. ഉത്ക്കണ്ഠയോ ആശങ്കയോ തോന്നാറില്ല
12. വേഗം ക്ഷീണിക്കാറില്ല.
13. വേദന, രോഗം എന്നിവ വിഷമിപ്പിക്കാറില്ല
14. വിഷാദമോ സങ്കടമോ തോന്നാറില്ല.
15. ജീവിതം പൊതുവെ തൃപ്തികരമാണ്.
16. സാധാണയായി പെട്ടെന്ന് ശുണ്ഠി പിടിക്കാറില്ല
17. എന്നെക്കൊണ്ട് ആവശ്യമുണ്ട്, ഉപയോഗമുണ്ട്, എന്നൊക്കെ തോന്നാറുണ്ട്.
18. ജീവിതം ക്രിയാത്മകവും ഫലപ്രദവുമാണെന്നു തോന്നുന്നു.
19. ഞാൻ എല്ലാറ്റിന്റെയും ഒരു ഭാഗമാണെന്നു തോന്നുന്നു.
20. ആരോഗ്യകരമായ സ്ഥിതിയിലാണ്

APPENDIX - D

AECOM COPING STYLE QUESTIONNAIRE (Mal.)

Shanty K.J. & Anita

DEPA
UNIVE

പേര്: വയസ്സ്: സ്ത്രീ/പുരുഷൻ: തീയതി:

വ്യത്യസ്ത സാഹചര്യങ്ങളിൽ ആളുകൾ എങ്ങനെയാണ് പെരുമാറുക എന്നും, വ്യത്യസ്ത കാര്യങ്ങൾ ഓരോരുത്തർക്കും എങ്ങനെയാണ് അനുഭവപ്പെടുക എന്നും വിവരിക്കുന്ന പ്രസ്താവനകളാണ് താഴെ കൊടുത്തിരിക്കുന്നത്. ഓരോ പ്രസ്താവനയും താങ്കളുമായി എങ്ങനെ ബന്ധപ്പെട്ടിരിക്കുന്നു എന്ന് സൂചിപ്പിക്കുവാൻ അനുയോജ്യമായ കോളത്തിൽ (ത) എന്ന് രേഖപ്പെടുത്തുക.

		ഒരിക്കലുമില്ല	അപൂർവ്വമായി	ചിലപ്പോൾ	മിക്കവാറും
1	ഞാനൊരു ശുഭാപ്തി വിശ്വാസിയാണ്				
2	അസുഖകരമായ കാര്യങ്ങൾ ചിന്തിക്കുന്നത് ഞാൻ ഒഴിവാക്കാറുണ്ട്				
3	എനിക്ക് ഒരു പ്രശ്നമുണ്ടാകുമ്പോൾ മറ്റുള്ളവരുടെ സഹായം തേടാറുണ്ട്.				
4	രോഗമോ അപകടമോ എന്റെ സാധാരണ ജോലികൾക്ക് തടസ്സമാവുകയാണെങ്കിൽ ഉപയോദപ്രദമായ മറ്റെന്തെങ്കിലും പ്രവൃത്തികൾ ഞാൻ കണ്ടെത്തും.				
5	മറ്റുള്ളവർ എനിക്കുവേണ്ടി തീരുമാനങ്ങൾ എടുക്കാതിരുന്നെങ്കിൽ സ്വന്തമായ തീരുമാനങ്ങൾ എടുക്കാമായിരുന്നു.				
6	ഞാൻ അസ്വസ്ഥനാവുന്ന സമയത്ത് എന്തെങ്കിലും ഭക്ഷിക്കും.				
7	തീരുമാനങ്ങൾ എടുക്കുന്നതിനുമുമ്പ് കിട്ടാവുന്നത്ര വിവരങ്ങൾ ഞാൻ ശേഖരിക്കും.				
8	അസ്വാസ്ഥ്യമുണ്ടാക്കുന്ന സന്ദർഭങ്ങളുടെ രസകരമായ വശം കണ്ടെത്താൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
9	ഉണ്ടാവാനിടയുള്ള ബുദ്ധിമുട്ടുകളെക്കുറിച്ച് ഞാൻ മുൻകൂട്ടി വേവലാതിപ്പെടാറില്ല.				
10	എന്റെ പ്രശ്നങ്ങളെക്കുറിച്ച് ചിന്തിക്കാതിരിക്കാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
11	എന്നേക്കാൾ നന്നായി കാര്യങ്ങൾ ചെയ്യാൻ കഴിവുള്ളവരുമായി ഇടപെടാൻ ശ്രമിക്കാറുണ്ട്.				
12	എന്റെ ശരീരഭംഗിക്കായി ഞാൻ പതിവായി വ്യായാമം ചെയ്യാറുണ്ട്.				
13	എന്റെ പലകാര്യങ്ങളും ശരിയാവാതിരിക്കുന്നത് മറ്റുള്ളവരുടെ കുറ്റംകൊണ്ടാണെന്ന് ഞാൻ വിചാരിക്കും.				
14	പ്രശ്നങ്ങളിൽ മനസ്സ് തിരിക്കാനായി ഞാൻ കഥാപുസ്തകങ്ങൾ വായിക്കാറുണ്ട്.				

15	എനിക്ക് ഒരു പ്രശ്നമുണ്ടാവുമ്പോൾ അത് പരിഹരിക്കാനായ് വ്യത്യസ്ത മാർഗ്ഗങ്ങളെക്കുറിച്ച് ഞാൻ ആലോചിക്കാറുണ്ട്.				
16	എനിക്ക് ഇഷ്ടമില്ലാത്തവരോട് നല്ല നിലയിൽ പെരുമാറാൻ ഞാൻ വളരെയധികം ശ്രദ്ധിക്കാറുണ്ട്.				
17	കാര്യങ്ങൾ മറ്റുള്ളവർ കരുതുന്നപോലെ അത്ര മോശമാണെന്ന് ഞാൻ കരുതുന്നില്ല.				
18	ശവസംസ്കാരചടങ്ങുകൾ ഞാൻ ഒഴിവാക്കാറുണ്ട്.				
19	ഞാൻ അസ്വസ്ഥനാകുമ്പോൾ മറ്റുള്ളവരുടെ ശ്രദ്ധയും പരിഗണനയും കിട്ടുന്നത് എനിക്ക് ഇഷ്ടമാണ്.				
20	ഒരു സുഹൃത്തിനെ നഷ്ടപ്പെട്ടാൽ മറ്റൊരു സുഹൃത്തിനെ ഞാൻ കണ്ടെത്തും.				
21	മറ്റുള്ളവർ ഇടപെടാതിരിന്നെങ്കിൽ എനിക്ക് കൂടുതൽ നേടാൻ കഴിയുമായിരുന്നു.				
22	ദേഷ്യം വരുന്ന സമയത്ത് ശാരീരികപ്രവർത്തനങ്ങളിൽ ഏർപ്പെട്ട് ഞാനത് തീർക്കാൻ ശ്രമിക്കും.				
23	ഏതു പ്രശ്നവും ഞാൻ സൂക്ഷ്മമായി വിശകലനം ചെയ്യാറുണ്ട്.				
24	ദേഷ്യംവരുമ്പോൾ ഞാനത് മറച്ചുവെക്കാൻ ശ്രമിക്കാറുണ്ട്.				
25	ഞാൻ എന്റെ വേദനകളും പ്രയാസങ്ങളും അവഗണിക്കാറുണ്ട്.				
26	സിനിമയിലെ മനസ്സിന് വിഷമം ഉണ്ടാക്കുന്ന് രംഗങ്ങൾ ഞാൻ കാണാറില്ല.				
27	അസുഖം വരുന്ന സമയത്ത് കിടന്ന് വിശ്രമിക്കാനും പരിചരിക്കപ്പെടാനുമാണ് എനിക്കിഷ്ടം				
28	ചെയ്ത ഒരു കാര്യം മോശമായാൽ ഭാവിയിൽ അത് മെച്ചപ്പെടുത്താൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
29	മറ്റുള്ളവർ ഇടപെടുന്നതുകൊണ്ട് എനിക്കെന്റെ ജോലികൾ ചെയ്യാൻ കഴിയാറില്ല.				
30	അസ്വസ്ഥതതോന്നുമ്പോൾ ഞാൻ ഒന്ന് നടക്കാൻപോകും.				
31	ഒരു തീരുമാനമെടുക്കുന്നതിനുമുമ്പ് അതിന്റെ നല്ലതും ചീത്തയുമായ വശങ്ങൾ ഞാൻ കണക്കിലെടുക്കാറുണ്ട്.				
32	ആൾക്കൂട്ടത്തിൽ നിൽക്കുമ്പോൾ ലജ്ജ തോന്നിയാലും കൂട്ടത്തിൽകൂടാൻ ശ്രമിക്കാറുണ്ട്.				
33	പ്രശ്നങ്ങൾക്ക് സ്വയം പരിഹാരമുണ്ടാവുമെന്ന് ഞാൻ വിചാരിക്കുന്നു				
34	ആശുപത്രിയിൽ കിടക്കുന്ന രോഗികളെ സന്ദർശിക്കുന്നത് ഞാൻ ഒഴിവാക്കാറുണ്ട്.				
35	പ്രധാനപ്പെട്ട എന്തെങ്കിലും വാങ്ങുന്നതിനുമുമ്പ് മറ്റുള്ളവരുടെ അഭിപ്രായം തേടാറുണ്ട്.				
36	ദുഃഖമുണ്ടാകുമ്പോൾ താല്പര്യമുള്ള മറ്റെന്തെങ്കിലും കാര്യങ്ങളിൽ ഏർപ്പെടാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
37	മറ്റുള്ളവർ എന്റെ ജീവിതത്തിൽ ഇടപെടുന്നത് നിർത്തിയാൽ ഞാൻ കൂടുതൽ നന്നാവുമായിരുന്നു.				
38	മാനസികാസ്വാസ്ഥ്യം അനുഭവപ്പെടുമ്പോൾ എന്തെങ്കിലും കൈവേല ചെയ്യാൻ ഞാൻ ഇഷ്ടപ്പെടുന്നു.				
39	പ്രശ്നങ്ങൾ പരിഹരിക്കുന്നതിനെക്കുറിച്ച് ആലോചിച്ച് ധാരാളം സമയം ഞാൻ ചില				

	വഴിക്കാറുണ്ട്.				
40	അസ്വസ്ഥത ഉളവാക്കുന്ന സന്ദർഭങ്ങളിൽ എന്തെങ്കിലും തമാശ പറയാൻ ഞാൻ ആലോചിക്കാറുണ്ട്				
41	അസുഖം വളരെ കൂടിയാൽ മാത്രമെ ഞാൻ ഒരു ഡോക്ടറെ കാണുകയുള്ളൂ.				
42	സന്തോഷപ്രദമായ സിനിമകൾ ഞാനൊഴിവാക്കാറുണ്ട്				
43	ഞാൻ അസ്വസ്ഥമാകുമ്പോൾ എന്നെ അലട്ടുന്ന കാര്യങ്ങൾ സംസാരിക്കാൻ ഒരാളെ കണ്ടെത്താറുണ്ട്				
44	അടുപ്പമുള്ള ആരെങ്കിലും മരിച്ചാൽ ആ നഷ്ടബോധത്തിൽനിന്ന് രക്ഷപ്പെടാൻ ഞാൻ ജോലിത്തിരക്കിൽ വ്യാപൃതനാകും.				
45	മറ്റുള്ളവരാണ് എന്റെ പ്രശ്നങ്ങൾ ഞാൻ മറക്കാറുണ്ട്				
46	സിനിമകാണുമ്പോൾ എന്റെ പ്രശ്നങ്ങൾ ഞാൻ മറക്കാറുണ്ട്				
47	എനിക്ക് ഒരു പ്രശ്നമുണ്ടാകുമ്പോൾ അത് പരിഹരിക്കാനാവശ്യമായ എല്ലാ മാർഗ്ഗങ്ങളെക്കുറിച്ചും ഞാൻ ചിന്തിക്കും				
48	ഞാൻ പരാതികൾ പറയുന്ന തരക്കാരനല്ല				
49	എല്ലാ ശരിയാകുമെന്നുറപ്പുള്ളതുകൊണ്ട് ഞാൻ ഒന്നിനെക്കുറിച്ചും മുൻകൂട്ടി ഉൽക്കണ്ഠപ്പെടാറില്ല.				
50	മരണത്തെക്കുറിച്ചുള്ള സംസാരം ഞാൻ ഒഴിവാക്കാറുണ്ട്				
51	അസ്വസ്ഥനാകുമ്പോൾ തനിച്ചിരിക്കുന്നത് ഞാൻ ഒഴിവാക്കാറുണ്ട്				
52	എന്റെ കഴിവുകേടുകളെ അതിജീവിക്കാൻ ഞാൻ കഠിനപ്രയത്നം ചെയ്യാറുണ്ട്				
53	എന്നോട് വാദിക്കാൻ വരുന്നില്ലെങ്കിൽ അവരോട് ഒത്തുപോകാൻ എനിക്ക് സാധിക്കും				
54	പല കാര്യങ്ങളും എന്നെ വല്ലാതെ അലട്ടുമ്പോൾ ഞാൻ ദിവാസ്വപ്നം കാണാറുണ്ട്				
55	എനിക്ക് ഗുരുതരമായ അസുഖമാണെന്ന് ഡോക്ടർ പറഞ്ഞാൽ അതിനെക്കുറിച്ച് കഴിയുന്നത്ര അറിയാൻ ശ്രമിക്കും.				
56	കൂട്ടത്തിൽ വച്ച് മനസ്സിലുള്ളത് പറയാൻ പരിഭ്രമം തോന്നിയാലും ഞാനതു പറയും				
57	എന്നെ അലട്ടുന്ന പ്രശ്നങ്ങളെ എനിക്ക് അവഗണിക്കാനാവും				
58	ദുഃഖിക്കുന്നവരെ ചെന്നു കാണുന്നത് ഞാനൊഴിവാക്കാറുണ്ട്.				
59	എനിക്ക് നന്നായിട്ടറിയാത്ത കാര്യങ്ങളെക്കുറിച്ച് ഞാൻ മറ്റുള്ളവരുടെ ഉപദേശം തേടാറുണ്ട്.				
60	വിഷാദം തോന്നുമ്പോൾ ഉന്മേഷമുണ്ടാക്കുന്ന മറ്റെന്തെങ്കിലും ചെയ്യാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്				
61	മറ്റുള്ളവർ എന്നോട് അനുഭാവം കാണിച്ചിരുന്നെങ്കിൽ എനിക്ക് കൂടുതൽ കര്യങ്ങൾ ചെയ്യാമായിരുന്നു.				
62	അസ്വസ്ഥനായിരിക്കുമ്പോൾ വായന എന്നെ ശാന്തനാക്കുന്നു.				
63	കുറെയധികം തീരുമാനങ്ങൾ എടുക്കേണ്ടി വരുമ്പോൾ അവയിലേതിനാണ് കൂടുതൽ പ്രാധാന്യം കൊടുക്കേണ്ടതെന്ന് ഞാൻ ആദ്യം കണ്ടെത്തും.				
64	ചമ്മലുണ്ടാക്കുന്ന സന്ദർങ്ങളിൽ ഒന്നും സംഭവിച്ചില്ലെന്ന് നടിക്കാൻ ഞാൻ ശ്രമി				

	ക്കാറുണ്ട്.				
65	വേവലാതിപ്പെടാൻ തക്ക പ്രശ്നങ്ങൾ ഒന്നുമില്ല എന്നെനിക്ക് തോന്നാറുണ്ട്				
66	അസ്വാരസ്യം ഉണ്ടാകുന്ന സന്ദർഭങ്ങൾ ഞാൻ ഒഴിവാക്കാറുണ്ട്				
67	കാര്യങ്ങൾ വിചാരിച്ചപോലെ നടക്കാതിരിക്കുമ്പോൾ എനിക്ക് എന്നോടുതന്നെ സഹതാപം തോന്നാറുണ്ട്				
68	എനിക്ക് അടുപ്പമുള്ള ആരെങ്കിലും മരിച്ചാൽ എന്നെപ്പോലെ വേർപാടിന്റെ ദുഃഖം അനുഭവിക്കുന്ന മറ്റാറുകളെ ഞാൻ സഹായിക്കും.				
69	എന്റെ ഡോക്ടർക്ക് നന്നായി അറിയാമെങ്കിൽ അദ്ദേഹത്തിന്റെ ഉപദേശം സ്വീകരിക്കാൻ ഞാൻ സന്നദ്ധനാകും.				
70	ഉൽക്കണ്ഠ തോന്നുമ്പോൾ ഞാൻ മറ്റുള്ളവരെ ഫോണിൽ വിളിക്കും.				
71	സങ്കടമുണ്ടാവുമ്പോൾ ഞാനതൊരു പുഞ്ചിരിയിലൊളിക്കാൻ ശ്രമിക്കാറുണ്ട്.				
72	ക്രമമായ ആരോഗ്യപരിശോധനകൾ സമയമഷ്ടമാണെന്നാണ് എന്റെ വിശ്വാസം.				
73	അലോസരപ്പെടുത്തുന്ന വാർത്തകൾ വായിക്കുന്നത് ഞാനൊഴിവാക്കാറുണ്ട്				
74	ഞാൻ അസ്വസ്ഥനാകുമ്പോൾ എനിക്കുണ്ടാകുന്ന വിഷമം മറ്റുള്ളവരെ അറിയിക്കാൻ ശ്രമിക്കാറുണ്ട്.				
75	ആദ്യ തവണ ചെയ്ത ഒരു കാര്യം ശരിയായില്ലെങ്കിൽ അത് പഠിച്ചെടുക്കാൻ എത്ര സമയം ചെലവഴിക്കാനും എനിക്ക് മടിയില്ല.				
76	മറ്റുള്ളവർ എന്നെ ചൂഷണം ചെയ്തില്ലെങ്കിൽ അവരുമായി ഒത്തു പോകാൻ എനിക്ക് കഴിയുമായിരുന്നു.				
77	അസ്വസ്ഥനാകുമ്പോൾ ആശ്വാസത്തിനായി ഞാൻ അല്പം മദ്യം കഴിക്കാറുണ്ട്.				
78	അപകടകരമാണെന്ന് തോന്നുന്ന ഒരു കായിക വിനോദത്തിൽ പങ്കെടുക്കാൻ എനിക്ക് ആഗ്രഹം തോന്നുകയാണെങ്കിൽ ഞാനതിനുവേണ്ടി ശ്രമിക്കും.				
79	കാര്യങ്ങൾ എത്രത്തന്നെ മോശമായാലും അതെന്നെ അസ്വസ്ഥനാക്കാൻ ഞാൻ അനുവദിക്കാറില്ല.				
80	മാനസികസ്വാസ്ഥ്യമുണ്ടാക്കുന്ന സന്ദർഭങ്ങളിൽ ആശ്വാസം നൽകുന്ന മരുന്നുകൾ ഞാൻ കഴിക്കാറുണ്ട്.				
81	പ്രശ്നങ്ങൾ നേരിടേണ്ടി വരുമ്പോൾ ഞാനാകെ തകർന്ന് പോകും				
82	എന്റെ ശാരീരിക വൈകല്യങ്ങൾ മറയ്ക്കുന്നതരം വസ്ത്രങ്ങളാണ് ഞാൻ വാങ്ങുക.				
83	നിരശ തോന്നുമ്പോൾ ഞാൻ ഭക്ഷണം കഴിക്കാറുണ്ട്				
84	ഊഴമെത്തുമ്പോൾ നടക്കും എന്ന വിശ്വാസമുള്ളതിനാൽ വെല്ലുവിളികൾ ഏറ്റെടുക്കാൻ എനിക്ക് ഭയമില്ല.				
85	ഒരു വിൽപത്രം തയ്യാറാക്കുക എന്ന ചിന്ത ഞാനൊഴിവാക്കാറുണ്ട്				
86	ആഹാരക്രമത്തിൽ ശ്രദ്ധിക്കുന്നത്കൊണ്ട് എന്റെ ശരീരവണ്ണം കൂടുന്നില്ല.				
87	ശ്മശാനങ്ങളിൽ പോകുന്നതും ശവസംസ്കാരചടങ്ങുകളിൽ പങ്കെടുക്കുന്നതിനും ഞാനൊഴിവാക്കാറുണ്ട്.				

APPENDIX - E

't' test on the effect of the nature of the family on stress tolerance, wellbeing, coping styles in the spouses of the manics.

Variables	Females (N=30)		Males (N=30)		Total
	Means	SDs	Mean	SDs	
Stress tolerance	220.96	32.40	225.23	34.33	0.50
Well being	10.00	4.28	8.03	4.98	-1.64
CS1	47.60	29.37	47.63	23.45	0.00
CS2	53.50	23.86	51.50	22.03	-0.34
CS3	68.96	21.68	62.43	25.16	-1.08
CS4	48.50	31.31	43.76	31.91	-0.58
CS5	46.93	26.38	55.76	27.60	1.27
CS6	43.410	27.97	40.50	27.52	-0.43
CS7	70.73	24.53	61.90	20.92	-1.50
CS8	36.86	27.96	41.70	29.73	0.65

't' test on the effect of the nature of the family on stress tolerance, wellbeing, and coping styles in the spouses of the schizophrenics (paranoid type).

Variables	Females (N=35)		Males (N=25)		Total
	Means	SDs	Mean	SDs	
Stress	277.65	37.33	277.68	19.60	0.00
Well being	6.05	2.47	5.48	2.38	-0.91
CS1	45.71	32.37	51.48	27.58	-0.74
CS2	43.65	25.27	50.60	26.16	1.03
CS3	80.94	17.15	78.08	18.18	-0.62
CS4	43.60	26.47	45.20	28.55	0.22
CS5	56.65	27.22	66.00	28.67	1.27
CS6	58.57	30.52	53.68	31.71	-0.60
CS7	43.20	29.84	55.76	31.09	1.57
CS8	47.65	31.72	53.36	29.35	0.72

't' test on the effect of the nature of the family on stress tolerance, wellbeing, and coping styles in the spouses of the depressives.

Variables	Females (N=30)		Males (N=30)		Total
	Means	SDs	Mean	SDs	
Stress	213.56	35.88	219.73	41.95	-0.61
Well being	9.33	4.02	10.86	4.45	1.40
CS1			54.50	31.63	-0.99
CS2	58.86	20.16	56.06	24.25	-0.49
CS3	55.43	33.96	67.23	20.87	1.62
CS4	33.46	31.56	42.20	35.60	1.01
CS5	36.53	26.60	35.73	28.86	-0.13
CS6	32.20	32.04	27.76	26.85	-0.58
CS7	64.66	27.89	63.80	29.80	-0.12
CS8	40.16	34.63	43.96	30.37	0.45

One-way ANOVA to find the differences between the spouses of the manics on stress tolerance, wellbeing and coping styles by the variable socio economic status.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	25.17	12.58	0.11
	WG	57	64882.2	1138.28	
	Total	59	64907.4		
Well being	BG	2	126.18	63.09	3.03
	WG	57	1184.80	20.78	
	Total	59	1310.98		
CS1	BG	2	710.02	355.01	0.50
	WG	57	40264.15	706.38	
	Total	59	40974.18		
CS2	BG	2	358.09	179.04	0.33
	WG	57	30290.90	531.41	
	Total	59	30649.00		
CS3	BG	2	40.27	20.13	0.03
	WG	57	32596.32	571.86	
	Total	59	32636.60		
CS4	BG	2	35566.83	1778.41	1.85
	WG	57	54764.08	960.77	
	Total	59	58320.93		
CS5	BG	2	5748.03	2874.01	4.34
	WG	57	38699.61	661.39	
	Total	59	43447.65		
CS6	BG	2	2725.89	1362.94	2.07
	WG	57	37472.95	657.42	
	Total	59	40198.85		
CS7	BG	2	76.45	38.22	0.06
	WG	57	31254.53	548.32	
	Total	59	31330.98		
CS8	BG	2	673.33	336.66	0.39
	WG	57	47994.84	842.01	
	Total	59	48668.18		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the manics on stress tolerance, wellbeing and coping styles by the variable religion.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	1623.49	811.74	0.731
	WG	57	63283.9	1110.24	
	Total	59	64907.4		
Well being	BG	2	25.34	12.67	0.56
	WG	57	1285.63	22.55	
	Total	59	1310.98		
CS1	BG	2	1952.18	976.09	1.42
	WG	57	39022.00	684.59	
	Total	59	40974.18		
CS2	BG	2	1084.35	542.17	1.04
	WG	57	29564.64	518.67	
	Total	59	30649.00		
CS3	BG	2	215.12	107.56	0.18
	WG	57	32421.47	568.79	
	Total	59	32636.6		
CS4	BG	2	1907.53	953.76	0.96
	WG	57	56413.39	989.70	
	Total	59	58320.93		
CS5	BG	2	1290.06	645.03	0.87
	WG	57	42157.58	739.60	
	Total	59	43447.65		
CS6	BG	2	156.87	78.43	0.11
	WG	57	40041.97	702.49	
	Total	59	40198.85		
CS7	BG	2	491.51	245.75	0.45
	WG	57	30839.47	541.04	
	Total	59	31330.98		
CS8	BG	2	122.28	61.14	0.37
	WG	57	48545.89	851.68	
	Total	59	48668.18		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the manics on stress tolerance, wellbeing and coping styles by the variable age.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	1450.71	725.35	0.65
	WG	57	63456.68	1113.27	
	Total	59	64907.40		
Well being	BG	2	86.41	43.20	2.01
	WG	57	1224.57	21.48	
	Total	59	1310.98		
CS1	BG	2	511.59	255.79	0.36
	WG	57	4046.58	709.86	
	Total	59	40974.18		
CS2	BG	2	234.53	117.26	0.21
	WG	57	30414.46	533.58	
	Total	59	30649.00		
CS3	BG	2	450.81	225.44	0.39
	WG	57	32185.70	564.66	
	Total	59	32636.60		
CS4	BG	2	2912.66	1456.33	1.49
	WG	57	55408.26	972.07	
	Total	59	58320.93		
CS5	BG	2	214.45	107.22	0.141
	WG	57	43233.19	739.60	
	Total	59	43447.65		
CS6	BG	2	2534.92	1267.46	1.91
	WG	57	37668,92	660.77	
	Total	59	40198.85		
CS7	BG	2	1329,93	664.96	1.26
	WG	57	30001.05	526.33	
	Total	59	31330.98		
CS8	BG	2	893.38	446.69	0.53
	WG	57	47774.79	838.15	
	Total	59	48668.18		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the schizophrenics (paranoid type) on stress tolerance, wellbeing and coping styles by the variable socio economic status.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	96.06	48.03	0.48
	WG	57	56527.27	991.70	
	Total	59	56623.33		
Well being	BG	2	3.20	1.60	0.26
	WG	57	345.78	20.93	
	Total	59	348.98		
CS1	BG	2	935.45	467.72	0.4989
	WG	57	53442.75	937.59	
	Total	59	54378.18		
CS2	BG	2	1061.10	530.55	0.80
	WG	57	37783.74	662.87	
	Total	59	38844.85		
CS3	BG	2	736.5472	368.27	1.21
	WG	57	17316.70	303.80	
	Total	59	18053.25		
CS4	BG	2	1162.17	581.08	0.78
	WG	57	42275.55	741.67	
	Total	59	43437.72		
CS5	BG	2	90.52	45.26	0.05
	WG	57	46116.322	809.05	
	Total	59	46206.85		
CS6	BG	2	837.54	418.77	0.43
	WG	57	55333.38	970.76	
	Total	59	56170.93		
CS7	BG	2	750.42	375.21	0.38
	WG	57	55042.30	965.65	
	Total	59	55792.73		
CS8	BG	2	844.39	422.19	0.44
	WG	57	54523.54	956.55	
	Total	59	55367.93		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the schizophrenics (paranoid type) on stress tolerance, wellbeing and coping styles by the variable age.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	2767.95	1383.97	1.46
	WG	57	53855.37	944.83	
	Total	59	56623.33		
Well being	BG	2	2.9582	1.47	0.24
	WG	57	346.02	6.07	
	Total	59	348.98		
CS1	BG	2	442.30	221.15	0.23
	WG	57	53.935.87	946.24	
	Total	59	54378.18		
CS2	BG	2	334.58	167.29	0.24
	WG	57	38510.26	675.61	
	Total	59	38844.85		
CS3	BG	2	606.32	303.16	0.37
	WG	57	17446.92	306.08	
	Total	59	18053.25		
CS4	BG	2	813.06	406.53	0.54
	WG	57	42629.6695	747.80	
	Total	59	43437.73		
CS5	BG	2	1615.38	807.69	1.03
	WG	57	44591.46	782.30	
	Total	59	46206.85		
CS6	BG	2	941.94	470.97	0.48
	WG	57	55228.98	968.92	
	Total	59	56170.93		
CS7	BG	2	522.06	261.03	0.26
	WG	57	55270.66	969.66	
	Total	59	55792.73		
CS8	BG	2	433.83	216.91	0.22
	WG	57	54934.09	963.75	
	Total	59	55367.93		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the schizophrenics (paranoid type) on stress tolerance, wellbeing and coping styles by the variable chronicity.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	874.78	437.39	0.44
	WG	57	55748.54	978.04	
	Total	59	56623.33		
Well being	BG	2	5.57	2.78	0.46
	WG	57	343.40	6.02	
	Total	59	348.98		
CS1	BG	2	1200.50	600.25	0.69
	WG	57	53177.67	932.94	
	Total	59	54378.18		
CS2	BG	2	460509	2302.54	3.83
	WG	57	34239.75	600.69	
	Total	59	38844.85		
CS3	BG	2	1315.92	657.96	2.24
	WG	57	16737.32	292.63	
	Total	59	18053.25		
CS4	BG	2	5062.06	2531.02	3.75
	WG	57	38375.67	673.25	
	Total	59	43437.73		
CS5	BG	2	1980.09	990.04	1.27
	WG	57	44226.75	775.90	
	Total	59	46206.85		
CS6	BG	2	2258.69	1129.34	1.19
	WG	57	53912.23	945.82	
	Total	59	56170.93		
CS7	BG	2	99.75	49.87	0.05
	WG	57	55692.97	977.06	
	Total	59	55792.73		
CS8	BG	2	798.44	399.22	0.41
	WG	57	54569.48	957.35	
	Total	59	55367.93		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the schizophrenics (paranoid type) on stress tolerance, wellbeing and coping styles by the variable religion.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	1901.79	950.89	0.037
	WG	57	54721.53	960.02	
	Total	59	56623.33		
Well being	BG	2	8.57	4.28	0.49
	WG	57	340.40	5.97	
	Total	59	348.98		
CS1	BG	2	2831.04	1440.52	0.21
	WG	57	51497.14	903.45	
	Total	59	54378.18		
CS2	BG	2	2361.13	1180.56	1.84
	WG	57	36983.71	640.06	
	Total	59	38844.85		
CS3	BG	2	545.10	272.55	0.88
	WG	57	17508.14	307.16	
	Total	59	18053.25		
CS4	BG	2	345.72	172.86	0.22
	WG	57	43092.01	756.00	
	Total	59	43437.73		
CS5	BG	2	623.07	311.53	0.38
	WG	57	45583.77	799.71	
	Total	59	46206.85		
CS6	BG	2	756.23	378.11	0.38
	WG	57	55414.69	972.18	
	Total	59	56170.93		
CS7	BG	2	2338.61	1169.30	1.24
	WG	57	53454.11	937.79	
	Total	59	55792.73		
CS8	BG	2	2329.23	1164.61	1.25
	WG	57	53038.69	920.50	
	Total	59	55367.93		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the schizophrenics (paranoid type) on stress tolerance, wellbeing and coping styles by the variable duration of marriage.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	260.50	130.25	0.13
	WG	57	56362.82	988.82	
	Total	59	56623.33		
Well being	BG	2	26.46	13.23	2.33
	WG	57	322.51	5.65	
	Total	59	348.98		
CS1	BG	2	1476.08	738.04	0.79
	WG	57	52902.10	928.10	
	Total	59	54378.18		
CS2	BG	2	2561.10	1280.55	2.01
	WG	57	36283.74	636.55	
	Total	59	38844.85		
CS3	BG	2	313.5146	156.75	0.50
	WG	57	17739.73	311.2234	
	Total	59	18053.25		
CS4	BG	2	1152.87	576.43	0.77
	WG	57	42284.85	741.83	
	Total	59	43437.723		
CS5	BG	2	2909.29	1452.14	1.91
	WG	57	43302.55	759.69	
	Total	59	46206.85		
CS6	BG	2	183.53	91.76	0.93
	WG	57	55987.40	982.23	
	Total	59	56170.93		
CS7	BG	2	263.56	131.78	0.13
	WG	57	55529.16	974.19	
	Total	59	55792.73		
CS8	BG	2	328.1686	164.08	0.16
	WG	57	55039.76	965.60	
	Total	59	55367.93		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the depressives on stress tolerance, wellbeing and coping styles by the variable socio economic status.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	387.15	193.57	0.12
	WG	57	88586.50	1554.14	
	Total	59	88973.65		
Well being	BG	2	63.03	31.51	1.77
	WG	57	1012.36	17.76	
	Total	59	1075.40		
CS1	BG	2	1000.50	500.25	0.48
	WG	57	58926.08	1033.79	
	Total	59	599926.58		
CS2	BG	2	1251.60	625.80	1.28
	WG	57	27725.33	486.40	
	Total	59	28976.93		
CS3	BG	2	113.11	56.55	0.67
	WG	57	48056.22	843.09	
	Total	59	48169.33		
CS4	BG	2	4998.52	2499.26	2.30
	WG	57	61797.80	1084.17	
	Total	59	66796.33		
CS5	BG	2	115.15	57.57	0.73
	WG	57	44573.83	781.99	
	Total	59	44688.98		
CS6	BG	2	4163.34	2081.67	2.53
	WG	57	46825.63	821.50	
	Total	59	50988.98		
CS7	BG	2	1766.81	883.40	1.08
	WG	57	46577.91	817.15	
	Total	59	55792.73		
CS8	BG	2	1190.62	595.31	0.56
	WG	57	60551.11	1062.30	
	Total	59	61741.73		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the depressives on stress tolerance, wellbeing and coping styles by the variable age.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	2041.24	1020.62	0.66
	WG	57	86932.40	1525.12	
	Total	59	88973.65		
Well being	BG	2	19.18	9.59	0.51
	WG	57	1056.21	18.53	
	Total	59	1075.40		
CS1	BG	2	112.61	56.30	0.05
	WG	57	59813.96	1049.36	
	Total	59	59926.58		
CS2	BG	2	1377.06	688.53	1.42
	WG	57	27599.87	848.20	
	Total	59	28976.93		
CS3	BG	2	608.4127	304.20	0.36
	WG	57	47560.92	834.40	
	Total	59	48169.33		
CS4	BG	2	306.24	153.12	0.13
	WG	57	66490.08	1166.49	
	Total	59	66796.33		
CS5	BG	2	70.38	35.19	0.45
	WG	57	44618.59	782.78	
	Total	59	44688.98		
CS6	BG	2	684.88	342.44	0.38
	WG	57	50304.09	882.52	
	Total	59	50988.98		
CS7	BG	2	2656.47	1328.23	1.65
	WG	57	45688.25	801.59	
	Total	59	48344.73		
CS8	BG	2	314.81	157.40	0.14
	WG	57	61426.92	1077.66	
	Total	59	61741.73		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the depressives on stress tolerance, wellbeing and coping styles by the variable chronicity.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	10044.77	5022.38	3.62
	WG	57	78928.87	1384.71	
	Total	59	88973.65		
Well being	BG	2	41.17	20.58	1.13
	WG	57	1034.22	18.14	
	Total	59	1075.40		
CS1	BG	2	5282.61	2641.30	2.75
	WG	57	54643.96	958.66	
	Total	59	59926.58		
CS2	BG	2	12.08	6.04	0.01
	WG	57	28964.89	508.15	
	Total	59	28976.93		
CS3	BG	2	419.75	209.87	0.25
	WG	57	47749.58	837.11	
	Total	59	48169.33		
CS4	BG	2	1803.83	901.91	0.79
	WG	57	64992.49	1140.21	
	Total	59	66796.33		
CS5	BG	2	2742.71	1371.35	1.86
	WG	57	41946.26	735.89	
	Total	59	44688.98		
CS6	BG	2	940.72	470.36	0.53
	WG	57	50048.26	878.03	
	Total	59	50988.98		
CS7	BG	2	1788.13	894.06	1.09
	WG	57	46556.59	816.78	
	Total	59	48344.73		
CS8	BG	2	1940.06	970.03	0.92
	WG	57	59.801.66	1049.15	
	Total	59	61741.73		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the depressives on stress tolerance, wellbeing and coping styles by the variable religion.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	3911.93	1705.96	1.13
	WG	57	85561.71	1501.08	
	Total	59	88973.65		
Well being	BG	2	22.20	11.10	0.60
	WG	57	1053.19	18.47	
	Total	59	1075.40		
CS1	BG	2	174.37	87.18	0.83
	WG	57	59752.20	1048.28	
	Total	59	59926.58		
CS2	BG	2	1227.01	613.50	1.26
	WG	57	27749.92	486.84	
	Total	59	28976.93		
CS3	BG	2	342.54	171.27	0.20
	WG	57	47826.78	839.06	
	Total	59	48169.33		
CS4	BG	2	3923.58	1961.79	1.77
	WG	57	62872.75	1103.03	
	Total	59	66796.33		
CS5	BG	2	1430.2606	715.13	0.94
	WG	57	43258.72	758.92	
	Total	59	44688.98		
CS6	BG	2	3701.39	1850.69	2.23
	WG	57	47287.56	828.60	
	Total	59	50988.98		
CS7	BG	2	7004.01	3502.00	4.82
	WG	57	41340.72	725.27	
	Total	59	48344.73		
CS8	BG	2	2532.56	1266.28	1.21
	WG	57	59209.1643	1038.75	
	Total	59	61741.73		

BG - Between groups, WG - Within groups

One-way ANOVA to find the differences between the spouses of the depressives on stress tolerance, wellbeing and coping styles by the variable duration of marriage.

Variables	Sources	DF	Sum of squares	Mean sum of squares	F
Stress tolerance	BG	2	9668.03	4834.01	3.47
	WG	57	19305.61	1391.32	
	Total	59	88973.65		
Well being	BG	2	35.38		0.96
	WG	57	1040.01	18.24	
	Total	59			
CS1	BG	2	1179.03	589.51	0.57
	WG	57	58747.54	1030.65	
	Total	59	59926.58		
CS2	BG	2	32.87	16.43	0.03
	WG	57	28944.0598	507.7905	
	Total	59	28976.93		
CS3	BG	2	125.48	62.74	0.74
	WG	57	48043.85	842.87	
	Total	59	48169.33		
CS4	BG	2	1414.00	707.00	0.61
	WG	57	65382.32	1147.05	
	Total	59	66796.33		
CS5	BG	2	165.89	82.94	0.10
	WG	57	44523.09	781.10	
	Total	59	44688.98		
CS6	BG	2	2849.13	1424.56	1.68
	WG	57	48139.84	844.55	
	Total	59	50988.98		
CS7	BG	2	1028.18	514.09	0.61
	WG	57	47316.54	830.11	
	Total	59	48349.73		
CS8	BG	2	1828.82	914.91	0.87
	WG	57	59911.90	1051.08	
	Total	59	61741.73	1051.08	

BG - Between groups, WG - Within groups