IOSR Journal of Humanities And Social Science (IOSR-JHSS)
Volume 25, Issue 9, Series 10 (September. 2020) 38-43
e-ISSN: 2279-0837, p-ISSN: 2279-0845.
www.iosrjournals.org

Gender Bias in the Rehabilitation of Persons with Mental Illness

Pravin B. Yannawar[1], Jahanara M. Gajendragad[2,] Sangeeta Gotewal[3],
1Psychiatric Social Work Consultant- Department of Psychiatric Social Work,
Institute of Human Behaviour and Allied Sciences, Delhi, India.
2Associate Professor & Head, Department of Psychiatric Social Work,
Institute of Human Behaviour and Allied Sciences, Delhi, India.
3Psychiatric Social Work Consultant- Department of Psychiatric Social Work,
Institute of Human Behaviour and Allied Sciences, Delhi, India.
Corresponding Author: Dr. Pravin B. Yannawar

Abstract:
Introduction: Rehabilitation of recovered persons with mental illness has always been a challenge not only in developed countries but also in developing countries and India is not an exception. Although joint family system has been considered as a buffer in India, unfortunately the concept is gradually eroding. The role that families play in the support and care of a relative with mental illness has gained increasing attention over the past 30 years. The goal of psychosocial rehabilitation is to enable an individual who suffers from mental illness to develop his or her capacities to the fullest extent.
Materials and Methods: The current study was aimed to understand the differential attitudes of the family members in accepting the male and female persons with severe mental illness. Two case studies, one male and female from the inpatient department, treated and rehabilitated from the Institute of Human Behaviour and Allied Sciences, Delhi were taken for the present study. Difficulties faced during the process of rehabilitation were noted down, and critically analyzed during the case study. Case studies analysed during the present studies clearly details the differential attitudes of the family members and their approach towards male and female patients. Often, there is a trend in taking the male persons to the hospital much sooner than female members, who often get neglected and become victim of differential treatment by family members.
Result: In the current study it was found that patient's chronic illness and compliance was one of the biggest problems with the family. Primary and secondary support systems have been robust in rural area. The close bonding was found with the neighbours in the rural areas. Gender bias was observed, while providing the treatment and after care.
Conclusion: It was observed that there has been differential treatment given by the family members while taking care of the persons with mental illnesses.
Key Words: Rehabilitation, Stigma, Reintegration.

Date of Submission: 12-09-2020 Date of Acceptance: 29-09-2020

I. INTRODUCTION

Rehabilitation of recovered persons with mental illness has always been a challenge not only in developed countries but also in developing countries and India is not an exception. Although joint family system has been considered as a buffer in India, unfortunately the concept is gradually eroding. There are multiple factors associated with the difficulties in rehabilitating persons with mental illness. It is also a well known fact that, stigma associated with mental illness is one of the principal causes for mentally ill people not receiving adequate mental health care and treatment. Stigma associated with mental illness can be considered as a major public health problem, because it has a negative impact on treatment seeking, adherence and effectiveness.

Community-based rehabilitation is a multi-dimensional approach to improve the function and quality of life of a mentally ill person. The evidence promotes community-based psychosocial rehabilitation as a feasible option for low and middle-income countries as it can be effectively delivered by trained lay health workers under supervision by the mental health specialist [1,2,3,4].

The traditional joint family that exists in India is seen as a source of social and economic support and is known for its tolerance of deviant behavior and capacity to absorb additional roles in times of crisis [5,6,7].

The role that families play in the support and care of a relative with mental illness has gained increasing attention over the past 30 years. The goal of psychosocial rehabilitation is to enable an individual who suffers from mental illness to develop his or her capacities to the fullest extent [8]. In conjunction with

individually oriented interventions, psychosocial rehabilitation stresses the importance of environmental factors in the care of people with long-term mental illnesses [9]. Family being the most immediate psychosocial milieu has a significant role in rehabilitation of chronic psychiatric patient.

According to the World Health Organization (WHO), "Worldwide it is estimated that, 450 million people suffer from mental disorders [10]." Among that, 80% of the people with mental disabilities live in low- and middle-income countries [11], four out of five people with serious mental disorders living in low- and middle-income countries; do not receive the much needed mental health services. Mental illness accounts for 14% of all disability adjusted life years (DALYs) lost worldwide[12,13], and is one of the major contributors to the global burden of disease[13].

The overt social and economic inequalities more commonly experienced by women, such as lower rates of schooling and employment, less pay for similar jobs, under representation in leadership positions, and the higher level of psychosocial stressors and problems, from caregiving burden to intimate partner violence, all contribute to these disparities [14.]

II. MATERIALS AND METHODS

This article aims to understand the differential attitudes of the family members in accepting the male and female persons with severe mental illness. Two case studies, one male and female from the inpatient department, treated and rehabilitated from the Institute of Human Behaviour and Allied Sciences (IHBAS) were taken for the present study. Difficulties faced during the process of rehabilitation were noted down, and critically analyzed during the case study.

The following two studies details the differential attitudes of the family members and their approach towards male and female patients. Often, there is a trend in taking the male persons to the hospital much sooner than female members, who often get neglected and become victim of differential treatment by family members.

III. RESULT

Case Study 1

Mr P. is a 32 year old unmarried male from lower middle socio economic status, belonging to rural area and studied up to 8th standard. Patient was admitted to Institute of Human Behaviour and Allied Sciences (IHBAS) in September 2008 by the court order. Patient was found wandering on the street, aimlessly wandering around public dustbin; people suspected him as planting bomb and informed the police. Later local police apprehended the patient and produced him before the Metropolitan Magistrate and he was admitted in IHBAS through reception order. Patient was having psychotic symptoms in the form of muttering to self, hallucinatory behaviour, poor self care and diagnosed as a case of Schizophrenia. He was not able to comprehend and respond to the interviewer initially. However after adequate treatment, he responded well and started interacting with the treating team. After few weeks of treatment, the patient started remembering his family details and was able to share his native place as Ranikhet, District Almora (Uttarakhand).

Based on the information provided by the patient, the office of the Superintendent of Police (SP) was contacted and the patient's details and his home town address were provided. However, they had expressed their inability to send someone from their police station to patient's hometown, as his village was in remote areas of District Almora. The SP office provided the contact number of nearest police station and subsequently the Chowki Incharge was contacted. Later the Chowki Incharge contacted the Postman working in that area, who used to visit frequently between the town and village. After sustained efforts of the Police team and Postman of that area, the patient's family members were contacted within a week of contact with the SP Office.

Subsequent to that, patient's brother contacted the treating team and explained about his brother's illness and the treatment taken by him in the past. Later, despite the economic hardship, patient's brother was able to manage the finance and come to Delhi. The patient's brother further shared that villagers were aware about patient's illness and reportedly most of them were cooperative with the family members as well, except a few making occasional fun of the patient. He further revealed that, patient was missing from the home since more than a year, so he was very happy to see the patient hale and hearty.

Case Study 2

Mrs. S. is a 38 year old married female, literate, belongs to semi urban areas of Distt. Pune. Patient was caught near New Delhi Railway Station along with her two year old daughter. Patient was not able to provide any details to police personnel and unable to comprehend anything. She was produced before the Metropolitan Magistrate, Tis Hazari Court, Delhi and as per the reception order she was admitted to IHBAS for further evaluation, management and treatment.

Patient was diagnosed as a case of Psychosis NOS and started on treatment. After 2-3 weeks of active treatment, the patient started responding well and was able to interact with the staff and other patients in the ward. However, due to language barrier (Patient was Marathi speaking), she was not able to converse with ease.

So subsequently, she was provided the Marathi speaking mental health professionals; after initial hesitation with the male therapist, rapport could be established. During the interaction it was noticed that, patient came out on street because of her mental illness as she was not having orientation, wandered, travelled aimlessly, took shelter whosoever offered her, lived with unknown persons during her ordeal.

Patient further stated that, she belongs to Chakan, Dist. Pune in Maharashtra, used to work as maid servant and travelled to Pune, Mumbai and worked at several houses. However, due to her psychiatric illness, she could not work at one place for considerable period of time, nor able to remember the details of the employer. She further stated that, she started living with one of such employer in Live-in relationship and has the two year old daughter from him. Despite the best efforts, patient was not able to provide the name and other details of the person. After periodic intervention and reassurance patient was able to give the contact details of her husband and other family members who were residing in Chakan, District Pune.

Later, Superintendent Office Pune was contacted and further details of the patient's family were procured. The Station House Officer of Chakan Police Station was briefed about the patient's details and her address and requested to trace the family members. Patient's husband's address was found but since he was working in the city, immediately he could not be contacted. However, after sustained efforts he was contacted and briefed about the patient's current status and her stay in IHBAS. To the utter shock of the counsellor, husband told that patient had left the home almost 8-10 years back and he presumed that she was no more and so he remarried. He simply refused to accept the patient, that too with two year old daughter whose father was not known.

As it was imperative that the patient had to be reintegrated back into her culture and community and also keeping the sensitive nature of the issue in mind, the local Sarpanch was roped in. His contacts were used while garnering the community support as well as convincing patient's husband in the process of reintegration. Along with Police Officer, Sarpanch and Patient's family multiple rounds of discussion were carried out and patient's husband was motivated to accept the patient or requested to reunite her with her family of origin. The local police officer was also requested to find out a suitable NGO, in case husband does not wish to accept the patient.

At Delhi, the Metropolitan Magistrate was also kept updated about the efforts towards patient's rehabilitation/integration with the family and simultaneously the discharge procedure was also followed by obtaining the necessary order. Marathi speaking Police officers were also arranged to escort the patient along with lady police constable for better coordination during handing over of the patient to the husband and ultimately reunited the patient with family of origin as well.

IV. DISCUSSION

Rehabilitation of persons with mental illness itself is a very challenging task. It becomes more difficult when the patient is female. In our society stigma towards with mental illness is a major barrier in rehabilitation of persons with mental illness. The society deals differently when gender issue comes in between. Males are easily accepted in the family whereas female patients face rejection by their families. In current study the male patient was happily accepted by the family and for female patient a lot of problems were encountered in the process of rehabilitation.

Because of different societies and their cultural values, social responsibilities, the impact of mental illness on women and men are different. Traditional psychiatric services which were based on a medical disease model have often failed to accommodate individual's needs based on gender[15]. Many of the symptoms associated with childhood abuse put women at heightened risk for re-victimization as adults. For women, a psychiatric episode may be directly produced by current experiences of physical or sexual or verbal abuse. Despite high prevalence rates, various studies report that mental health professionals seldom explore histories of current or past abuse faced by women with psychiatric illness. Failure to do so would contribute to ignoring important issues essential to women's recovery process in treatment and rehabilitation[16, 17, 18, 19].

Women who are victims of sexual assault or rape face societal stigma and are often viewed as being sexually promiscuous, and lustful. Mental disorders have been linked with alienation, dependence, and poverty, especially in the Indian situation. These conditions are more frequently experienced by women as a result of multiple factors. Study reports reveal that among people who had psychiatric problems, more women than men got married. However, more married women than men were deserted, abandoned, or divorced. In addition, many of them had to face physical abuse and violence from husbands prior to separation. In contrast, majority of men who got married were cared for and financially supported by their wives [20]. The onset of serious mental disorder in women usually occurs in early adulthood and studies have pointed out that the normal development and maintenance of social roles such as sibling, spouse, and parent may be interrupted and are often irretrievably scarred[21]. The damage that happened to their relationships earlier in life had resulted in retarded development of relationships and reduced social support later in life. During the illness phase, mostly women are sent to their family of origin; though they do not have any claim there. Even after recovery, they have to face the ongoing

threat of divorce either from husband or from the in-laws. Later in life, children may reject or disown them, when these grown up children face social stigma. Such situations of insecurity, uncertainty, and social ostracism would make their state all the more difficult later in life to cope with the aging experience [22].

The mental health problems of gender violence victims who normally do not seek psychiatric help is getting visibility and is causing to widen the boundaries of the mental health system. That study revealed that the health care system, which has to play a proactive role generally, is unresponsive to the women victims of gender violence [23]. A woman seeking medical help for physical injuries or pain would be treated symptomatically, even when she makes several visits for recurrent injuries or pain. Instead of probing into the possibilities for domestic violence she would be viewed as a "problem patient."

Rehabilitation of the male patient, response from family members or relative was very good, but at the same time, response from female patient's family members was very discouraging, they didn't show any pleasure or happiness, rather were shocked to know about her alive status. The counsellor had to convince the family members and beg for their support. Even, the counselors have to reach out to the Village Sarpanch and rope him in handling hostile attitude of the family members and ensure smooth discharge process. Discharging mentally ill women back into a community which is not ready to receive them is fraught with evil consequences. A family who is not ready to accept the mentally ill woman back into its fold, is unlikely to ensure adherence to treatment and regular follow-ups and the woman is thus at a risk of repeated relapses and worsening of her psychiatric condition. Stigma and discrimination by the society may abet abandonment and exposure to both physical and sexual abuse [24].

Important issues in rehabilitation of male patient:

1. Patient's chronic illness and compliance was one of the biggest problems with the family.
2. Rural and remote areas: where connectivity was a hurdle. Getting access to the patient's hometown or village was not easy, however the postman working in the remote area was found to be instrumental in tracing the family and bringing them to the Institute.
3. Cooperation from the police and postman was highly appreciable for rehabilitation of the patient. There was a optimum communication and coordination among the counsellor, police, postman and the patient's family.
4. Positive attitude of the family members: Since the beginning the family was receptive and cooperative. Despite the hardship & financial constraints the patient's brother assured about the proper medication as well as regular follow up at the nearby psychiatric facilities.
5. Social support. Primary and secondary support systems have been robust in rural area. The close bonding was found with the neighbours in the rural areas.

Important issues in rehabilitation of female patient:

1. Patient's long term illness and poor compliance: Patient was diagnosed as case of Schizophrenia, had taken treatment from different hospitals but was having poor compliance.
2. Multiple relationship problems due to illness: During the progress of illness, patient came in contact with several persons, has been subjected to exploitation. Patient was also having a daughter from live in relationship or otherwise, which is a not clear, so family member were reluctant to take her back in the family.
3. Language barrier: Patient was Marathi speaking, had difficulties while communicating in other languages, as she was staying in a mental health Institution in Delhi.
4. Remarriage of patient's husband: Since patient was missing from home since long, patient's husband got remarried and had children. So in the changing scenario, there was difficulty in welcoming the patient back in the family.
5. Social support: There was poor primary level of support, as the family members were not cooperative. There was no bonding found between husband and wife. However there was good tertiary level of support available for the patient in the form of help from Police and Sarpanch. Stigma attached with mental illness, was very much evident while communicating with the police personnel, Village Sarpanch and patient's husband himself.

The aim of the present study was, to bring out the range of issues related to mental health across gender and to study the families' attitude. Typically Indian patriarchal society gives lot of attention to male persons as compared to female persons. As it is very evident, stigma attached to mental illness is very much prevalent. There has been enough literature which talks about stigma in rural and urban areas, literate and illiterate and on other parameters. Many a times family members show promptness in bringing the male patient regularly to the hospital, but very unfortunately that is not the case with female members.

With the institution of family crumbling because of rapid urbanization and industrialization, the society in general and policymakers must be sensitized to realize the importance of fostering the institution of family for the sake of those ill fated mentally ill people who will be the ultimate sufferers because of lack of mental health

infrastructure in India. Time has come to take a positive step towards full integration of family in the care of the mentally ill to combat the ill effects of this changing world and make this world a happier place to live in [25.]

V. CONCLUSION

In the current study it was evident that, there has been differential treatment given by the family members while taking care of the persons with mental illnesses. As discussed earlier the patriarchal society does play an important role in the overall management of the family system in India and it is the same with male and female clients in both urban and rural areas.

There are multiple challenges in the treatment, management and rehabilitation of the persons with mental illnesses. The scenario seeming to be better in the rural areas now seems to be a myth. Due to rapid urbanization the distance between rural and urban areas has been shortened, so are the values, principles and the culture.

The government is also focusing on various options regarding the rehabilitation of recovered persons with mental illness, by opening short stay and long stay homes across the country, but society also needs to come forward and give its best in dealing with such crucial subject. With proactive steps of the Government towards health and mental health, the management of mental illness and other such issues may become quite encouraging.

There is a constant need to create awareness about mental illness, sensitize about the core issues of treatment and rehabilitation. Integration of the recovered persons with mental illness is paramount; the ultimate goal will be to the make the person self reliant and function to his/her fullest capacity and potential.

REFERENCES

[1]. Asher L, Fekadu A, Hanlon C, Mideksa G, Eaton J, Patel V, et al. Development of a community-based rehabilitation intervention for people with schizophrenia in Ethiopia. PLoS One. 2015;10:e0143572. [PMC free article] [PubMed] [Google Scholar]

[2]. Asher L, Patel V, De Silva MJ. Community-based psychosocial interventions for people with schizophrenia in low and middle-income countries: Systematic review and meta-analysis. BMC Psychiatry. 2017;17:355. [PMC free article] [PubMed] [Google Scholar]

[3]. Balaji M, Chatterjee S, Koschorke M, Rangaswamy T, Chavan A, Dabholkar H, et al. The development of a lay health worker delivered a collaborative community-based intervention for people with Schizophrenia in India. BMC Health Serv Res. 2012;12:42. [PMC free article] [PubMed] [Google Scholar]

[4]. Chatterjee S, Naik S, John S, Dabholkar H, Balaji M, Koschorke M, et al. Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): A randomised controlled trial. Lancet. 20.

[5]. Sethi BB, Chaturvedi PK. A review and role of family studies and mental health. Indian J Soc Psychiatry. 1985;1:216–30. [Google Scholar]

[6]. Sinha D. Some recent changes in the Indian family and their implications for socialization. Indian J Soc Work. 1984;45:271–86. [Google Scholar]

[7]. Leff J, Wig NN, Bedi H, Menon DK, Kuipers L, Korten A, et al. Relatives' expressed emotion and the course of schizophrenia in Chandigarh. A two year follow-up of a first contact sample. Br J Psychiatry. 1990;156:351–6. [PubMed] [Google Scholar]

[8]. Fine SB. Psychiatric treatment and rehabilitation: What's in a name? J Natl Assoc Priv Psychiatr Hosp. 1980;11:8–13. [PubMed: 10250262]

[9]. Liberman RP, Phipps CC. Innovative treatment and rehabilitation techniques for the chronically mentally ill. In: Menninger WW, Hannah GT, editors. Chronic Mental Patient. Washington, DC: American Psychiatric Press; 1987.

[10]. World Health Organization. Risks to Mental Health: An overview of vulnerabilities and risk factors. Background paper by WHO secretariat for the development of a comprehensive mental health action plan. 2012. [Last accessed on 2014 May 12]. Available from: http://www.who.int/mental_health/mhgap/risks_to_mental_health_EN_27_08_12.pdf .

[11]. World Health Organization. Report of Global Health Observatory. 2010. [Last accessed on 2014 May 12]. Available from: http://www.who.int/gho/en .

[12]. Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No health without mental health. Lancet. 2007;370:859877. [Google Scholar]

[13]. Mathers CD, Loncar D. Projections of global mortality and burden of disease from 2002 to 2030. Plos Med. 2006;3:e442. [PMC free article] [PubMed] [Google Scholar]

[14]. World Health Organization. Health topics: Gender https://www.who.int/healthtopics/gender.(accessed 20/09/2020).

[15]. Worrell J. Feminist interventions: Accountability beyond symptom reduction. Psychol Women Q 2001;25:335-43.
[16]. Alexander MJ, Muenzenmaier K. Trauma, addiction and recovery: Addressing public health epidemics among women with severe mental illness. In: Lubotsky-Levin B, Blanche A, Jennings A, editors. Women′s Mental Health Services: A Public Health Perspective. Thousand Oaks, CA: Sage; 1998.
[17]. Newmann JP, Greenley D, Sweeney JK, Van Dien G. Abuse histories, severe mental illness and the cost of care. In: Lubotsky-Levin B, Blanche A, Jennings A, editors. Women′s Mental Health Services: A Public Health Perspective. Thousand Oaks, CA: Sage; 1998.
[18]. Mowbray CT, Oyserman D, Lutz C, Purnell R. Women: The ignored majority. In: Spaniol L, Gangue C, Koehler M, editors. Psychological and Social Aspects of Psychiatric Disability. Boston: Centre for Psychiatric Rehabilitation; 1997.
[19]. Rose SM, Peabody CG, Statigeas B. Undetected abuse among intensive case management clients. Hosp Community Psychiatry 1993;44:666-70.
[20]. Schizophrenia Research Foundation (SCARF). A study of mentally ill/disabled women who have been separated/divorced. Chennai: SCARF; 1998.
[21]. Seeman MV. Psychopathology in women and men: Focus on female hormones. Am J Psychiatry 1997;154:1641-7.
[22]. Stromwall LK, Robinson EA. When a family member has a schizophrenic disorder: Practice issues across the family life cycle. Am J Orthopsychiatry 1998;68:580-9.
[23]. Mowbray CT, Lanir S, Hulce M, editors. Women and Mental Health: New Directions for Change. New York: Harrington Park Press; 1985.
[24]. Rajni Chatterjee, Uzma Hashim. Rehabilitation of mentally ill women. Indian Journal of Psychiatry. 2015 Jul; 57(Suppl 2): S345–S353.
[25]. Ajit Avasthi. Preserve and strengthen family to promote mental health Indian. 2010 Apr-Jun; 52(2): 113–126.

Dr. Pravin B. Yannawar, et. al. "Gender Bias in the Rehabilitation of Persons with Mental Illness." *IOSR Journal of Humanities and Social Science (IOSR-JHSS)*, 25(9), 2020, pp. 38-43.