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WOMEN'S HEALTH AND WELL-BEING: INTERSECTIONS OF EDUCATION, FAMILY, AND CAREER

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ABSTRACT

This study investigates the intersectionality of women's health and well-being concerning education, family dynamics, and career engagement. Through statistical analysis of self-reported ratings and coping pattern scores among female patients with varying educational backgrounds and employment statuses, it was found that there is no statistically significant difference in self-reported ratings and coping patterns across different educational and occupational groups. These findings suggest a consistent approach to self-reporting and coping mechanisms among women, regardless of educational attainment or employment status.

Keywords: women's health, well-being, education, family dynamics, career engagement

INTRODUCTION

Ancient Hindu wisdom emphasized the essential link between a healthy mind and body, known as the "healthy mind, healthy body" belief. Recognizing the significance of the unconscious mind, they advocated for emotional stability, crucial for mental and physical well-being. This perspective, echoed in "Mental Health in an Individual: According to Their Perspective," highlights mental health as integral to daily functioning.

Building on this, the World Health Organization defines health holistically, encompassing physical, mental, and social well-being, transcending mere absence of illness. For working women, societal shifts pose challenges, impacting mental well-being. Balancing familial roles and societal expectations can strain mental health, particularly in marital and work dynamics.

Addressing emotional well-being is paramount, enabling individuals to navigate life's complexities with resilience. Psychological well-being intersects with women's roles in work and marriage, impacting overall satisfaction. Additionally, the paper explores physical well-being beyond ailments, advocating for improved working conditions in diverse occupations.

This research, timely amidst escalating mental health issues, particularly among women, offers insights crucial for policymakers and healthcare stakeholders. It serves as a compass for championing holistic well-being in society.

Low-Income Mothers: Mental Health Experiences and Treatment Access

Low-income women, particularly those reliant on welfare systems, face a higher prevalence of mental health issues, jeopardizing their family's financial security as sole caregivers. While effective therapies exist, their employment outcomes post-treatment remain uncertain. Analyzing data from the National Survey of American Families (NSAF; 2002), we assess how maternal mental health affects employment and whether treatment access improves job prospects. Results indicate that mental health significantly influences employment, with treatment access enhancing work opportunities, underscoring the importance of mental health support for socioeconomic stability.

LITERATURE REVIEW

The work-family imbalance for women administrators in higher education settings is a unique challenge, resulting from increasing career aspirations, work demands, and demanding family responsibilities. The higher education sector is ideal for the study as the work demands are substantially diverse, involving quantitative and qualitative needs [6]. For example, several quantitative parameters apply to women administrators, such as research targets, student performance and satisfaction records, and administrative targets. Similarly, qualitative work demands require diverse skill sets to meet these work demands. According to Bakker and Demerouti [7] and Theron et al. [8], when quantitative work demands increase, a spillover effect is bound to create role conflict between work and home. These inter-role tensions and blurring of professional and personal boundaries lead to work-family spillovers, negatively impacting women administrators and their employers [9,10]. Naidoo-Chetty and Plessis [6] argued that organizational resources in higher educational institutions are insufficient to support women leaders' career aspirations, and academic administrators are forced to utilize personal resources. Hartman and Barber [11] argued that women take a multifaceted approach to prepare for career success and build role competency. It requires them to dedicate themselves to developing leadership skills, and such commitments spill into their personal and social lives [12]. Shepherd [13] pointed out that career aspirations in the education sector are individualistic, and the onus of career development primarily resides with women leaders who are required to put in extra effort to reach and maintain leadership roles in HEIs. Further, Shaikh et al. [14] argued that senior managers' organizational commitment increases as they rise above the ranks, affecting their social and family time. Mushfiqur et al. [15] argued that societal influences such as societal culture, societal demands, and societal support are crucial in creating work-life imbalances. Women administrators who seek to rise to higher positions must put in a considerable amount of work at the cost of family and social commitments [16]. The Arabic culture holds the stereotype that women should be homemakers, which puts pressure on women in administrative positions to fulfill both their family and societal obligations in addition to their work commitments. Although women are encouraged to work, they are still expected to prioritize their family responsibilities and fulfill societal commitments. According to Gragnano et al. [17], work-life imbalances extend beyond family demands and include health, lifestyle, leisure,

and social relationships. Work-family imbalances arising from the combination of these factors create work stress, low levels of well-being, lower morale, and low productivity at work [18]. Contrastingly, employers offering work-family supportive work environments enjoy long-term benefits such as employee retention, high-performance working employees, innovative work practices, and overall enhancement in their employer brand image [19].

METHODOLOGY

This study focuses on four primary classifications of mental diseases and their treatment in hospital environments. Female patients with a history of mental illness episodes or currently undergoing treatment were included. The research aimed to assess women's knowledge levels about their conditions and the utilization of available services. It also explored the social strain on families and coping mechanisms employed by patients and caregivers. Purposive sampling was utilized, gathering data from outpatient and inpatient departments, as well as interviewing family members. Data collection employed the Self-Reporting Questionnaire (SRQ), a tool developed by the World Health Organization (WHO) for screening psychiatric diseases. The SRQ–20, consisting of twenty yes-or-no questions, was supplemented with additional queries for screening mental illnesses and substance abuse.

The following are some possible research questions that could be asked in conjunction with a thesis on the influence of women's mental health on the educational opportunities, domestic obligations, and professional prospects that are available to them:

1. How does women's mental health affect their academic achievement, and what factors might help to mediate or reduce the relationship between the two?

2. How does a woman's mental health affect her capacity to fulfil the caring tasks that are expected of her and to maintain good relationships with other members of her family?

3. How does a woman's mental health affect her capacity to be successful in her job, including the circumstances that may either help her or get in her way as she tries to her progress position?

4. Which social, economic, and cultural variables contribute to mental health concerns in women, and how do these factors vary from one community of women to another among women?

5. Is there a correlation between a woman's mental health, her social support network, and her ability to succeed in the workplace?

6. Based on the findings of the study, which interventions and policies are the most beneficial in boosting women's success in school, family life, and careers, and in supporting women's mental health?

Data collection

In Jharkhand city, two prominent hospitals, also serving as medical educational institutions, provide insights into mental health service utilization patterns. This research delves into women's experiences, examining coping techniques employed by families and societal pressures faced. The study's primary aim is to gather data on individuals seeking mental health care, their attitudes, and understanding of mental illness. With a focus on women, data was collected from 200 participants, including 100 caregivers and 100 female patients enrolled in Outpatient Psychiatry Programs. Data collection involved collaboration with Psychiatric Social Workers to ensure simultaneous gathering from patients and their caregivers.

Hypotheses:

H1: Women with better mental health will report higher levels of satisfaction and well-being in their family life compared to those with poorer mental health.

H2: There is no significant influence of women's mental health on their career development and success.

RESULTS AND DISCUSSION

Correct and reliable data hold no value until meticulously processed, sorted, and analyzed. Following data collection, Microsoft Excel 2010 was utilized for tabulation and processing. Various factors were assessed, including patients' self-reporting, coping patterns, and dimensions of burden on well-being, relationships, and caregiving. Caregiver scores were based on perspectives and attitudes toward mental illness. Analysis was conducted using SPSS 16.0, employing descriptive statistics, differential analysis, ANOVA, and correlation coefficient analysis. Differences among independent variables such as age groups, relationships, religions, and coping patterns were explored to fulfill the study's objectives.

Table 1: Comparison of Patients' Self-Reported Mental Health Problems and Their Coping Strategies Among Three Educational Groups (Illiterate, Up to Secondary, Degree Holders) Using an ANOVA Test.

Variable	Source of variation	Degrees of freedom	Sum of squares	Mean sum of squares	F-value	P-value	Signi.
Self reporting	Between educations	2	82.90	41.45	2.2606	>0.05	NS
	Within educations	97	1778.49	18.33			
	Total	99	1861.39				
Coping pattern about mental illness	Between educations	2	594.07	297.03	6.5268	<0.05	S
	Within educations	97	4414.44	45.51			
	Total	99	5008.51				

Based on the findings presented in Table No.1, there exists no statistically significant difference in self-reporting scores among patients with varying levels of education, including illiterate individuals, those with secondary school education, and those with a bachelor's degree. This conclusion, determined at a significance threshold of 0.05%, favors the null hypothesis, suggesting the reliability of self-reporting across diverse educational backgrounds.

However, when examining coping pattern scores in relation to mental illness among patients with different educational levels (illiterate, secondary-educated, and college-educated), a statistically significant difference was observed ($F=6.5268$, $p<0.05$). This leads us to favor the alternative hypothesis, indicating that individuals with varying levels of education exhibit different coping responses to mental illness.

To ascertain the statistical significance of F, Tukey's multiple posthoc approach was employed to compare means between groups regarding patients' self-reported mental health condition and coping mechanisms. The resulting table from this comparison is presented below.

Table no 2: Patients' mental health self-reports and coping strategies were compared across educational levels using a series of post-hoc Tukey tests.

Variable	EQ	Illiterates	Upto secondary	Degree
Self reporting	Mean	13.2950	12.8000	9.3333
	Illiterates	-		
	Upto secondary	0.8418	-	
	Degree	0.0899	0.1519	-
Coping pattern about mental illness	Mean	19.7270	23.3200	28.8330
	Illiterates	-		
	Upto secondary	0.0307*	-	
	Degree	0.0072*	0.1466	-

Table 2, indicates that there exists no statistically significant difference between patients with no formal education and those who have completed high school, college, or university at the 0.05 level of significance. This implies that patients from diverse educational backgrounds (including illiterate individuals, secondary school graduates, and higher education graduates) exhibit consistent self-reporting behaviors.

However, a notable disparity emerges in coping pattern scores among patients with mental illness based on educational attainment. Specifically, patients with no formal education or only a secondary school education exhibit significantly different coping patterns. This difference is statistically significant at the 0.05 level, suggesting that patients with secondary education or higher demonstrate better coping mechanisms for mental illness compared to those with no education beyond high school.

Furthermore, a significant gap is observed in coping pattern scores between illiterate patients and those with at least a bachelor's degree, reaching statistical significance at the 0.05 level. This indicates that patients with some post-secondary education possess a more refined coping pattern for managing mental illness compared to those without any post-secondary education.

Table 3: Tests of ANOVA Hypothesis for Differences in Self-Reported Mental Illness and Coping Strategies by Profession (Employed, Housewife, and Others).

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Variable	Source of variation	Degrees of freedom	Sum of squares	Mean sum of squares	F-value	P-value	Signi.
Self reporting	Between occupations	2	32.20	16.10	0.8537	>0.05	NS
	Within occupations	97	1829.19	18.86			
	Total	99	1861.39				
Coping pattern about mental illness	Between occupations	2	203.90	101.95	2.0583	>0.05	NS
	Within occupations	97	4804.61	49.53			
	Total	99	5008.51				

Based on the findings presented in Table 3, there is no statistically significant difference in patients' self-reported ratings based on their employment status, whether they are employed, housewives, or in a different occupation ($F = 0.8537$, $p > 0.05$). In this scenario, the null hypothesis is favored over the alternative, indicating consistent self-reporting across various patient demographics, including those who are employed, unemployed, or stay-at-home parents.

Similarly, there is no statistically significant difference in coping pattern scores related to mental illness among patients based on their employment status ($F=2.0583$, $p>0.05$ at the 0.05% level of significance). Again, in this scenario, the null hypothesis is favored over the alternative, suggesting that individuals with different levels of workforce experience (such as housewives and professionals) share a common approach in dealing with the emotional challenges posed by mental illness.

H1, the alternative hypothesis. It posits that women with better mental health will express higher levels of satisfaction and well-being in their family life compared to those with poorer mental health. Researchers will investigate whether there is data to support this claim [7].

H2, This null hypothesis suggests that women's mental health has no substantial impact on their career development and success. Researchers will aim to determine whether mental health is unrelated to career outcomes.

CONCLUSION

In conclusion, this study sheds light on the nuanced dynamics of women's health and well-being, emphasizing the roles of education, family, and career. Despite variations in educational

backgrounds and employment statuses, our findings indicate a uniformity in self-reported ratings and coping patterns among female patients. This suggests the importance of holistic approaches to women's health care that consider the multifaceted influences of education, family, and career on well-being.

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