Psychological Morbidity among Married Women of Reproductive Age Group Living In Rural Jammu: A Cross Sectional Study

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ABSTRACT

Background: Globally, one in three women will be afflicted by common mental disorders including depression by the year 2020(WHO). The study was conducted to assess the prevalence of psychological morbidity and its relationship with various Socio-demographic factors among women of reproductive age group living in a rural area of Jammu district.

Methods: This was a field-based cross-sectional study conducted in village Tanda of R.S.Pura Block, Jammu district. Using purposive sampling, 197 eligible women who agreed to participate were interviewed. Data was collected using a pretested Self Rating questionnaire-20 (SRQ-20). The data so collected was first entered into a master chart on Microsoft Excel spreadsheet and analyzed using it and SPSS 20 .0 software.

Results: The mean age of the study participants was 32.27± 7.87years.the prevalence of psychiatric morbidity was found to be 22.3% among the study population. A significant association of age at marriage and the presence of psychological morbidity was seen. 70.5% of those with psychological morbidity were married before the age of 21 years.

Conclusion: There is an urgent need to develop women-friendly health policies to improve the mental health of Indian women.

Key Words: SRQ-20, Rural women, Psychological health

INTRODUCTION

Till the year 2000 AD, Mental health was a neglected dimension of health as reflected by the fact that it failed to find a place in Millennium Development Goals. However, the Global Burden of Disease Report 2010 drew the focus of the world leaders towards this little or unattended aspect of health. The reason for this shift of attention was that two psychological mental disorders, i.e. Depression and anxiety emerged as one of the top 10 causes of disability in most regions of the world. Surprisingly, Depression was among the top three ranks of disability causes in the majority of regions of the world.[1]

Women generally suffer more than men from Common Mental Disorders (CMD)-depression, anxiety and somatic complaints. Approximately 1 in 3 people in the community suffer from these disorders, thus posing a serious public health problem.[2, 3] Studies of Psychological construct of mental health show that it deeply embedded within an individual's social and socioeconomic relationships.

The Self Reporting Questionnaire (SRQ-20) is the most widely used instrument for screening of suspected psychological morbidity cases. The traditional method is to define individuals who reach a certain cutoff as CMD cases. This cutoff is set based on gender: six or more positive answers for men as they are more likely to yield. [4-9]

Globally, women face discrimination and disadvantage at every stage of their lives. However, in

the majority of South Asian countries including India, they suffer from a lot of gender-based which in turn have a negative impact on their psychological well being and mental harmony. Since there is little data available regarding psychological morbidity in women especially from Northern India, we decided to explore the prevalence of the problem of psychological morbidity and its various issues among women among in reproductive age group living in a rural setting of Jammu.

METHODOLOGY

After seeking permission from the Institutional Ethical Committee, GMC, Jammu, the present study was carried out in R.S.Pura block, field practice area of PG Department of Community Medicine, GMC, situated at distance 24 km from Jammu city. The main source of livelihood of the population is agriculture. In terms of religion, this village has a mixed population.

From the list of villages falling under this block, village Tanda of Zone Simbal was randomly selected for this cross sectional study. All the married women of the reproductive age group (15-45 years) who met our eligibility criteria and were willing to participate in this study by giving informed consent were interviewed from October 2018 to November 2018.

Inclusion criteria: All those married women, apparently healthy, who agreed to participate in our study and were included in study.

Exclusion criteria: All those married women who were sick with any illness for more than 5 days and/or suffering from any chronic disease were excluded from the study. Those who didn't give consent or were not available even after visiting the household twice were also excluded.

Method of data collection:

At time of field visit, on reaching a particular household; firstly the participants were explained the purpose of this study and then verbal informed consent was sought. Thereafter, for building rapport with the study participants, the investigator interviewed them, in their local dialect regarding socio-demographic details. Thereafter, they were subjected self-administered study tool i.e SRQ-20. However, they were helped by the investigators in case if any participant wanted any clarification or was unable to read or understand SRQ-20 items. Also, at the time of interview the privacy of participants was maintained so participants could feel comfortable to give their answers freely. Information regarding socio-demographic factors like age, occupation, education, socioeconomic class, age at marriage was collected on a predesigned semi structured Proforma which also included Modified Uday Pareek scale.[10,11] Psychiatric morbidity was assessed using Self Rating Questionnaire (SRQ-20).[4,5] This questionnaire is 20 items scale with options of Yes or No in answer. This psychiatric morbidity screening scale was developed by the WHO, specifically for the LMIC primary healthcare setting. Case criteria were set at ≥8 cut off score point on SRQ-20 for this study. A single interview took around lasts for 20-30minutes.

Statistical analyses: The data collected was compiled and coded and entered in Microsoft excel 2007. The qualitative data was presented as percentages and quantitative data as mean (±SD). Chi square test was used to find the association. The level of significance was set at p-value of ≤0.05.

RESULTS

A total of 197 women were included in the study. The mean age at marriage was 20.8±7.87 years. More than half (i.e 51%) of the study participants were ≤30 years. As per the Modified Uday Pareek scale, most of the women in this study belonged to the middle class (45.1%) followed by lower middle class (41.6%). 56.3% of study women had received up to or above secondary level education.

Table 1: Socio Demographic profile of the study participants

Variable	No. of married women (%)
Age groups (in years)	
<30	101(51.26)
40-49	61(30.96)
50-59	35(19.76)
Socioeconomic class	
Upper	0
Upper middle	18(9.1)
Middle	89(45.2)
Lower middle	82(41.6)
Lower class	8(4.1)
Education	
Illiterate	32(16.2)
Upto primary	13(6.6)
Up to Middle	41(20.8)
Up to Secondary	53(26.9)
Up to Hr. Secondary	44(22.3)
Graduate /above	14(7.1)
Occupation	
House wife	174(88.3)
Labour	8(4.1)
Service	13(6.6)
Business	2(1.0)
Age at marriage	
<21 years	107(54.3)
≥21 years	90(45.7)

Table 2: Association of socio-demographic variables with psychological morbidity as per SRQ-20 scores

Variable	Psychological morbidity		Total (N=297)	Chisquare	P
	Present (%)	Absent (%)			
Age groups (in years)					
<30	17(16.83)	84(83.16)	101(100)	6.20	0.04*
40-49	14(22.95)	47(77.04)	61(100)		
50-59	13(37.14)	22(62.85)	35(100)		
Socioeconomic class					
Upper middle	3(17.6)	14(82.4)	17(100)	7.47	.058
Middle	16(17.4.)	76(82.6)	92(100)		
Lower middle	25(31.2)	55(68.8)	80(100)		
Lower class	0	8(100)	8(100)		
Education					
Illiterate	11(28.2)	28(71.8)	39(100)	9.59	.088
Up to primary	4(30.8)	9(69.2)	13(100)		
Up to Middle	14(35.9)	25(64.1)	39(100)		
Up to Secondary	7(13.2)	46(86.8)	53(100)		
Up to Hr. Secondary	6(15.0)	34(85.0)	40(100)		
Graduate /above	2(15.4)	11(84.6)	13(100)		
Occupation					
Not employed	37(22.56)	127(77.43)	164(100)	0.28	0.86
employed	7(21.21)	26(78.78)	33(100)		
Age at marriage					
<21 years	31(70.6)	76(49.7)	107(100)	5.94	0.015*
≥21 years	13(29.6)	77(50.3)	90(100)		

*Significant at P-value<.05

The majority of the women (i.e. 88.3%) were housewives. **(Table 1)**. Psychiatric morbidity was found to be present among 22.3% (SQR score >8) of the study participants.

There was a significant association between age at marriage and presence of psychological morbidity (p=0.015). Of those who had psychological morbidity, 70.5% of the women were married before the age of 21 years. Other demographic parameters like education, social economic class and occupation exhibited non-significant association with the SRQ-20 scores.**(Table 2)**

DISCUSSION

The prevalence of psychological morbidity in our study was found to be 22.3%. The findings are consistent with those reported by **Fahey et al. (2016)[12]** and **Soni et al. (2016),** wherein both reported psychiatric morbidity as 22.8% among rural females. However, **Tawar et al. (2014)[13]** reported that the prevalence of psychiatric distress was 27.27%. A study from Western Kenya[14] and Syria[15] reported comparatively higher prevalence i.e. about 45.5%and 55.8% respectively. In contrast, another study conducted in Kenya[16] reported, comparatively, lower prevalence of CMD (i.e. 17.3 %) among rural females. Since women in our settings, are still stress of coping with day-to-day domestic work and job pressures, meeting expectations of their

families and raising children along with facing a lot of gender based discrimation.

In contrast to the results of **Fahey et al.(2016)[12]** and **Maziaka et al. (2002)[14]** who reported significant association of age and educational status with psychiatric distress, our study found no significant association. In the present study, a strong association (p=0.015) between psychiatric common mental disorders and early age at marriage was seen. Similar findings were observed between age and psychiatric morbidity in a survey conducted by **Patel et al.(2006)[16]**.The reasons for this could less maturity in dealing with marital responsibilities and relationship pressures that women have to undergo the following marriage.

Strength and limitations of the study:

The main strength of our study lies in the study tool used i.e. SRQ–20 which has been found as valid and reliable for screening mental disorders across different cultural settings.[9]Since, the data was collected on the house to house survey, in private and calm places taking care of all the situational contamination, this adds to the strength of this study. Owing to that fact, this study is based on the small sample size and clustering nature of our sample cannot be ruled out, the finding of this study cannot be generalized. This could be regarded as a limitation of this study. Even though SRQ–20 is a tool for general screening of non-psychotic mental distress but it neither assesses a

full range of psychiatric conditions nor provides specific diagnoses.[9] This could be regarded as another limitation of our study.

The results of this study reveal a quite high prevalence of psychological morbidity, which cannot be ignored. It could serve as a stepping stone for the finding. Our research study highlights urgent focus policymakers toward this aspect of mentalwell being in order to improve the health of the women.

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